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Cover photo: **"Glistening Tower"**
by Alan V. Abrams, M.D.
First place, color category
Med Chi 1994 Annual Photo Contest

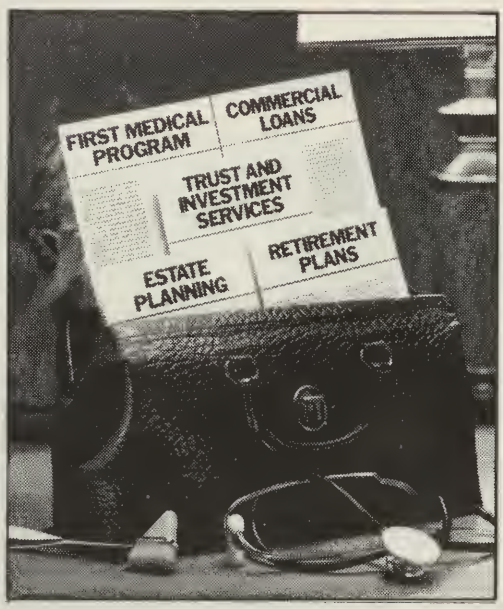
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To enter this year's photo contest, see page 60

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Mark Your 1995 Calendars

January 28, 1995, Med Chi Reference Committees and House of Delegates Meetings, Med Chi Faculty Building

March 8, 1995, Med Chi President's Southern Regional Conference, Holiday Inn, Waldorf, MD (for physicians in Calvert, Charles, Howard, St. Mary's, and Anne Arundel counties)

May 4 - May 6, 1995, Med Chi Annual Meeting, The Inn and Conference Center (formerly known as the Adult Education Center), College Park, MD

September 8 - September 10, 1995, Med Chi Semiannual Meeting, Royale Princess Hotel, Ocean City

Med Chi Library to Hold Book Sale

The Med Chi Library will have a book sale on Saturday, January 28, 1995, from 10:00 a.m. to 2:30 p.m. at the Faculty building. Duplicates from recent donations, the remainder of the Chirurgical Bookshop, and out-of-scope items from the regular collection will be featured. All proceeds will go to support the library's acquisition budget. If you have any questions, please call Margaret Burri, Library Administrator, at 410-539-0872 or 1-800-492-1056 ext. 354.

Performing Arts Medicine Conference

Performing Arts Medicine III: Pain and the Performer, a conference on special problems of performing artists, is scheduled for March 31-April 1, 1995 at the Faculty building. Presented by the Med Chi Committee on Medicine and the Performing Arts, this conference will include sessions on outcome measurements after upper extremity surgery, noise-induced hearing loss, breathing difficulties, vocal malfunction, health screening for dancers, and health management for optimal performance. Special features of the conference will include a discussion and demonstration of pain management resources available on the Internet, and three master classes. For further information, please contact Susan Harman at 410-539-0872 or 1-800-492-1056, ext. 403.

Cable TV Program Seeks Participants

"The Doctor's In," a cable TV program airing weekly in Montgomery County on channel 49 (cable-ready channel 23), is looking for participants for future programs. The 30-minute program is produced and hosted by Larry Sheingorn, M.D., and covers health-related topics as well as social, political, and policy issues related to health care. For further information, call Dr. Sheingorn at 301-963-9751.

Shanbacker Named Executive Director, Medical Society of D.C.

Ed Shanbacker, executive director, Montgomery County Medical Society (MCMS), has accepted the position of executive director of the Medical Society of the District of Columbia effective January 30, 1995. Mr. Shanbacker has been the executive director of MCMS since 1986 and joined the staff of that medical society in 1980 as assistant executive director. Med Chi wishes Ed every success in his new position.

PBS Medicare Part B Operations

On January 1, 1995, Pennsylvania Blue Shield's Medicare Part B operations will begin operating under the name Xact Medicare Services. PBS chose the name *Xact* to represent the ideal level of service and quality PBS wants to provide. PBS believes that the name emphasizes accuracy, detail, and precision.

Med Chi Testifies Before the Maryland Insurance Administration on Proposed BlueCross BlueShield of Maryland Restructuring

On Monday, December 19, 1995, Med Chi President Donald H. Dembo, M.D., General Counsel Angus R. Everton, Esq., and Controller Glen C. Burger, CPA, testified on behalf of Med Chi at a public hearing before the Maryland Insurance Administration regarding BlueCross and BlueShield of Maryland's (BCBSM) proposed restructuring plan.

As described by BCBSM in 282 pages of documentation filed with the insurance administration on November 7, 1994, the restructuring plan would form an "initially wholly-owned" for-profit subsidiary (referred to in the proposal as the Managed Care Company and/or MCC) of BCBSM. The new subsidiary will own all BCBSM's current health maintenance organizations (Free State, Care First, Potomac, Delmarva and Columbia health plans), as well as third party administrator Willse & Associates, Inc. The reorganization plan also proposes the formation of two additional subsidiaries of BCBSM—an indemnity insurance company and an insurance sales agency. BCBSM would transfer all the stock of its wholly-owned managed care subsidiaries and certain assets (including furniture, equipment, and the majority of its current employees) to the Managed Care Company in exchange for all the stock initially issued by the Managed Care Company. The Managed Care Company plans, in the near future, to issue and sell additional stock in a public offering. The BCBSM parent and a charitable foundation would continue as not-for-profit entities. The boards of directors and management teams of the not-for-profit and for-profit companies, although not identical, consist of many of the same people.

In preparation for the hearing, Med Chi members including Joseph Berkow, M.D., and Howard L. Seigel, M.D., and staff reviewed the documents filed by BCBSM. During their testimony, Med Chi representatives expressed many concerns regarding BCBSM's restructuring and the documentation provided by BCBSM about the restructuring. In particular, Med Chi and many others providing testimony felt that the public had not been given adequate time to study the documents filed with the insurance administration by BCBSM and that pro forma financial statements contained in this documentation were incomplete. With respect to the pro forma financial statements, Mr. Burger stated, "there is no independent tax opinion included in this filing which could indicate the taxable or non-taxable transfer of assets from this reorganization of BCBSM to its proposed for-profit subsidiary." Mr. Burger also stated that none of the balance sheets contained enough supporting information for analysis of the projections they contained.

Mr. Everton testified that the changes proposed by BCBSM needed to be approved by "at least two-thirds of the company's certificate holders who have voted on the procedure," and that "the interlocking directorates and the sharing of senior officer positions between BCBSM and MCC is also especially worrisome, leading to concerns of almost inevitable conflict-of-interest problems between the corporations."

In his testimony, Dr. Dembo asked that the Commission "not entertain this proposal until such a time as complete information has been provided, and the opportunity has been afforded to study in detail that information...."

As of press time, the insurance commissioner had not made a ruling on the BCBSM proposal or indicated when he will make a ruling. BCBSM wanted to complete the reorganization by December 31, 1994.

IRS Penalizes Two Providers

The IRS has announced that one of the ways it will provide guidance to tax-exempt entities will be by publicizing high-profile abuse cases. Recently, the IRS has taken action against two tax-exempt hospital providers: a provider known as LAC Facilities in Miami and Hermann Hospital in Houston.

After an audit of LAC's 1988 Form 990, the IRS found that several million dollars of company assets and earnings inured to the private benefit of officers, trustees, key employees, and other insiders to include excessive compensation paid to officers/trustees and insiders, and interest-free, unsecured loans to a partnership with interests held by officers/trustees and key employees of the organization. In addition, the IRS found that private medical practices were purchased from physicians in excess of fair market value and that expenses were incurred for purposes other than those specified by §501(c)(3), including payments for country club charges, catering services, liquor, gift items, and spouse travel. LAC had its tax-exempt status revoked effective October 1, 1985, and federal income tax returns were ordered to be filed for 1987 and all subsequent years with the exempt status revocation.

In the Hermann Hospital case, the hospital entered into a settlement agreement and was required to pay approximately $993,000 and almost $10,000 in penalties. Hermann Hospital acknowledged a lack of legal and board review, awareness of, and control over, particular actions undertaken from 1989 through 1992, which included: 1) incentives offered and provided to newly-recruited physicians, including income guarantees, office personnel salary support, free office space, subsidized parking, equipment loans, etc., with no required repayment or performance of specific duties in exchange for the benefits; 2) incentives (income guarantees, free rent, salary support for office personnel, etc.) offered and provided to full-time faculty members of the University of Texas Medical School in connection with their becoming full-time private practitioners in the hospital's community, with no requirement of repayment; 3) the operation of certain hospital outpatient departments in a manner resembling the private office practice of the physicians providing the services—physicians were acting as independent contractors and not as employees; and 4) certain purchases and other transactions that may have benefited certain former board members and other individuals.

Clinical Laboratory Improvement Amendments (CLIA) Information

The Commission on Office Laboratory Accreditation (COLA) in Silver Spring, Maryland (800-298-8044), is a private, nonprofit educational and accreditation program for physician office labs. To prepare labs for CLIA inspections, COLA has developed a 299-question, self-administered questionnaire. Furthermore, nearly 6,000 physician office labs have enrolled in COLA's accreditation program, which is recognized by the Health Care Financing Administration (HCFA). Sources indicate that COLA's inspections cost less than HCFA's inspections.

To obtain HCFA's CLIA inspection manuals, which include survey procedures and interpretive guidelines to help prepare for inspections, call the National Technical Information Service at 800-553-6847 and ask for PB92146174 and PB93950012.

The Medical Group Management Association (MGMA) provides "Directions: Quality Assurance Manual for Physician Office Laboratories." Call 303-397-7888 to obtain a copy.

Medicare Update

Fee Schedule

(Source: *Federal Register*, December 8, 1994)

The 1995 Physician Fee Schedule updates are:

- 12.2% increase for surgical services;
- 7.9% increase for primary care services, which consist of office visits, nursing home visits, house calls, emergency room visits, and ophthalmology visits of new patients; and
- 5.2% increase for other non-surgical services (including anesthesia).

Physician Care Plan Oversight

Effective January 1, 1995, Medicare will be making separate payment for care plan oversight services provided to Medicare home health agency and hospice patients. Payment will be limited to one physician per patient per month if 30 or more minutes of oversight services are provided in the month.

Limiting Charges

Under Medicare law, no person is liable for payment of any amounts billed in **excess of the limiting charges.** Physicians and other providers who charge more than the limiting charge can be fined or excluded from the Medicare program.

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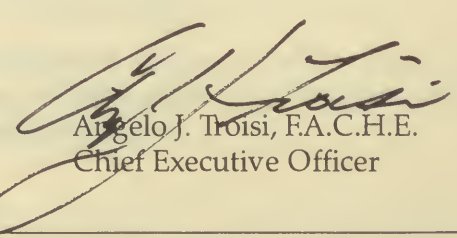
The 1995 update factor for durable medical equipment is a 2.5% increase. There is no increase for prosthetics and orthotics.

NIDA Releases Data on Practices of Chronic Drug Abusers

The National Institute on Drug Abuse (NIDA) has published a report entitled "Drug Procurement Practices of the Out-of-Treatment Chronic Drug Abuser." The report presents findings of a survey of injecting drug users and crack cocaine users in ten U.S. cities. Analysis of the data obtained through individual interviews focused on patterns of drug use, expenditures for drugs, acquisition of drugs, and sources of income for chronic drug abusers. A copy of the report can be obtained from the National Clearinghouse for Alcohol and Drug Information at 1-800-729-6686. It is publication number BKD154.

"Beyond Hearing Loss" Program Offered Free

The Johns Hopkins Center for Hearing and Balance is offering "Beyond Hearing Loss," a program for older people with hearing loss. The program is a free educational service that includes a 12-minute video; a brief talk that outlines steps for getting appropriate hearing help; and a resource guide with referral information and tips to improve communication at home. Interested persons can call the center at 410-955-6680.



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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

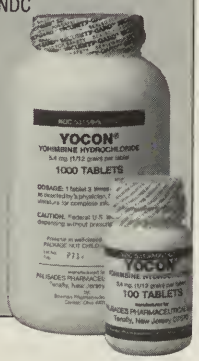
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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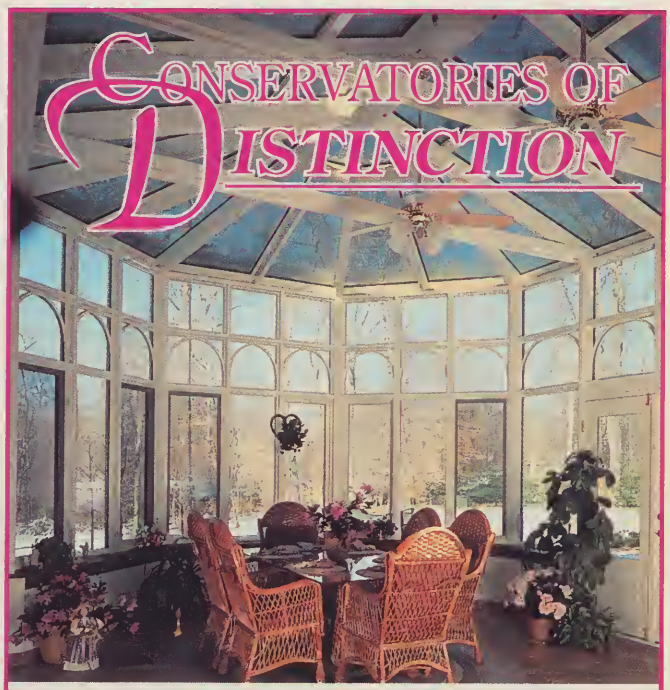
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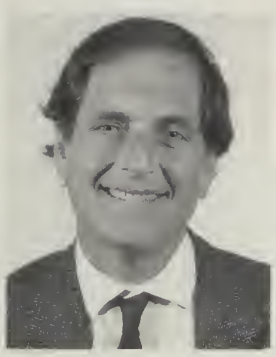
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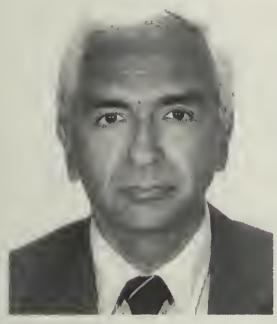
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Members in the News



SHELDON B. BEARMAN, M.D., director of ultrasound at Franklin Square Hospital and for Drs. Copeland, Hyman & Shackman, P.A., in Baltimore, was named a fellow of the American College of Radiology. Dr. Bearman is a diplomate of the American Board of Radiology and a member of many medical and professional societies. A former president of medical staff at Franklin Square Hospital, Dr. Bearman is very active in hospital activities and committees. As a Med Chi member he has served in the House of Delegates and on several committees, including the finance and hospital medical staff committees. Dr. Bearman received his bachelor of arts degree at the University of Pennsylvania and earned his medical degree at the University of Maryland School of Medicine. He served his internship at Mount Sinai Hospital in New York, completed his radiology residency training at Johns Hopkins Hospital, and served a fellowship with the National Institute of Health Diagnostic Radiology Training Grant.



DINO E. FLORES, M.D., an otlolaryngologist-head and neck surgeon from Bethesda, was recently presented with the American Academy of Otolaryngology-Head and Neck Surgery's honor award for continued service to the Academy. Originally from Peru, Dr. Flores received his medical degree from the University of San Marcos in Lima. Upon coming to the United States, he served his internship at the Bon Secours Hospital and his residencies at St. Agnes and the University of Maryland hospitals in Baltimore. Board certified in otolaryngology, Dr. Flores currently serves as chairperson of the department of otolaryngology and director of the neurotology unit at Suburban Hospital and is former chairperson of the department of otalaryngolgy at Shady Grove Adventist and Montgomery General hospitals. In addition, Dr. Flores is chairperson of the Committee on Computers in Medicine at the Medical and Chirurgical Faculty of Maryland. He is a fellow of the American College of Surgeons and the American Academy of Otolaryngology, Head and Neck Surgery, and a member of several medical societies, including the American Neurotology Society, the American Rhinologic Society, the Pan-American Medical Society, and the University of Maryland Surgical Society.



JOHN D. REEDER, M.D., co-director of MRI for Drs. Copeland, Hyman & Shackman, P.A., in Baltimore, and president of the Maryland Radiology Society, was recently named a fellow of the American College of Radiology. Dr. Reeder earned his medical degree from the University of Maryland School of Medicine and interned in the department of pediatrics at the University of Florida. He did his residencies in the department of radiology at the University of Florida and Johns Hopkins University hospitals, and was chief resident of the department of radiology at Hopkins. Certified by the American Board of Radiology, Dr. Reeder is a member of several medical societies and organizations. He is currently attending radiologist at Franklin Square Hospital and an instructor in the department of radiology and radiological science at the Johns Hopkins University School of Medicine. Dr. Reeder has published more than 25 scientific articles and abstracts and given numerous presentations on radiological topics.



STEPHEN C. SCHIMPFF, M.D., executive vice president of the University of Maryland Medical System, has been appointed to a second four-year term as a member of the National Board of Medical Examiners, representing the Association of American Medical Colleges. Board certified in internal medicine, medical oncology, and infectious diseases, Dr. Schimpff received his medical degree from Yale Medical School. He interned and did his residency at Yale-New Haven Hospital in Connecticut, and received a fellowship with the division of infectious diseases at the University of Maryland School of Medicine and with the National Institute of Allergy and Infectious Diseases at the National Institutes of Health. A fellow of the American College of Physicians

and the Infectious Diseases Society of America, Dr. Schimpff is very active in numerous medical and professional societies. In addition, he is involved with many civic activities, including having been president of the American Cancer Society, Maryland Division. Dr. Schimpff has written and/or coauthored over 200 published scientific articles and book chapters, and has served on the editorial boards of several journals. He is currently professor of clinical pharmacy at the University of Maryland School of Pharmacy, and professor of oncology, pharmacology, and medicine at the University of Maryland School of Medicine.



NANCY I. ULANOWICZ, M.D., of Prince Frederick, recently received a three-year appointment as Cancer Liaison Physician for the Hospital Cancer Program at Calvert Memorial Hospital. Dr. Ulanowicz has provided leadership and support to this program, which is an integral part of the Commission on Cancer of the American College of Surgeons. Board certified in anatomic and clinical pathology, Dr. Ulanowicz has a significant interest in the diagnosis and treatment of patients with malignant diseases. She is a fellow of the College of American Pathologists, a council member of the Maryland Society of Pathologists, and a member of the American Society of Clinical Pathologists and the Mid-Atlantic Forensic Pathology Association. A board member of the Calvert Memorial Hospital Foundation, Dr. Ulanowicz is involved with several committees at the hospital. She received her medical degree from the University of Maryland School of Medicine, did her internship at Union Memorial Hospital, and returned to the University of Maryland for her residency at the hospital. Dr. Ulanowicz is presently laboratory director at Calvert Memorial Hospital.

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PSA Financial Center is sponsoring a workshop on Estate Planning

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Presenter: Chris A. Owens, Esq.
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- updating your will
- various strategies to minimize estate and gift taxes
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Location: PSA Financial Center, Lutherville, MD

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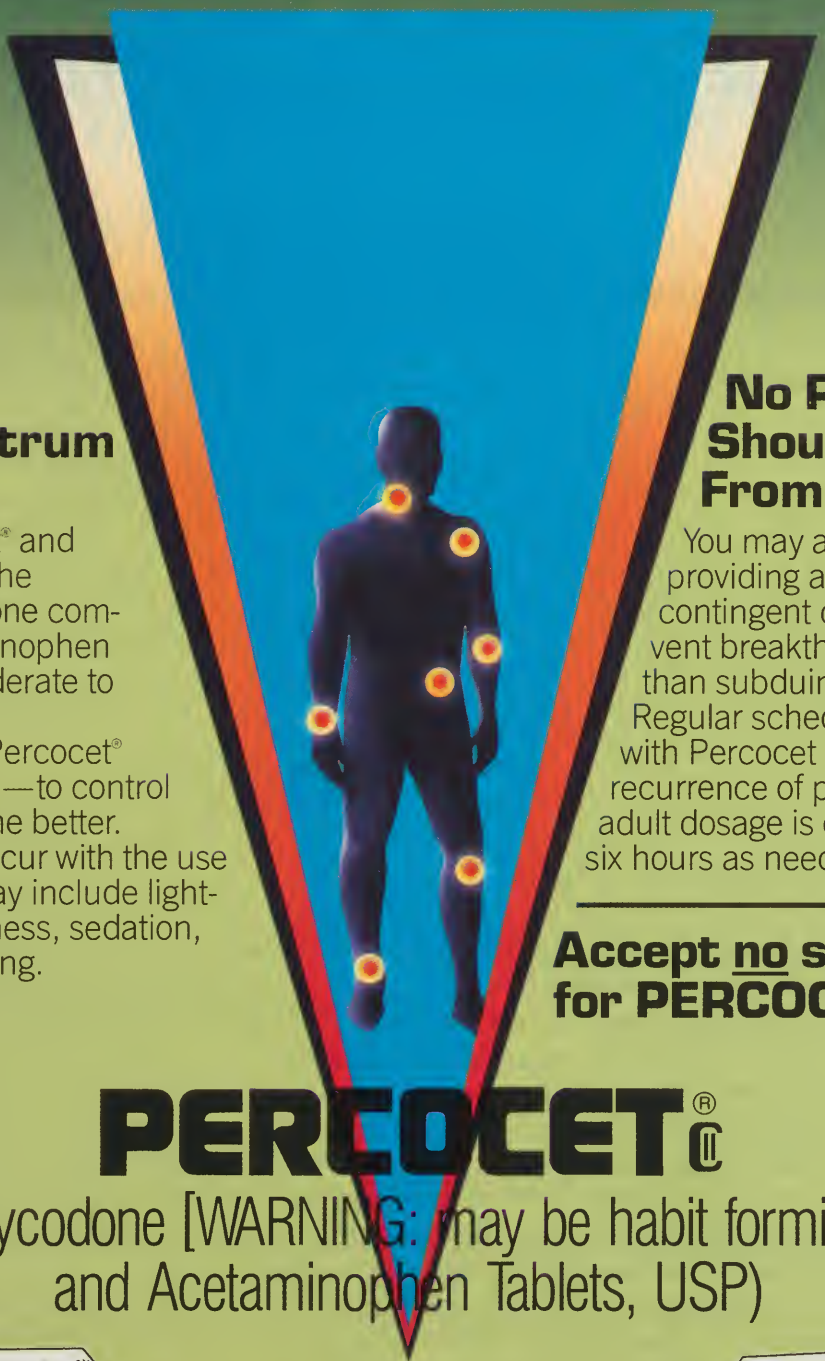
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RELY ON PERCOCET® C II TO

(Oxycodone [WARNING: may be habit forming] and Acetaminophen Tablets, USP)

CONTROL PAIN.
THE SOONER THE BETTER



Effective Broad Spectrum Pain Relief

Prescribe Percocet® and give your patients the benefits of oxycodone combined with acetaminophen for the relief of moderate to severe pain.
You can count on Percocet® due to its analgesia—to control pain...the sooner the better.
Side-effects may occur with the use of Percocet and may include lightheadedness, dizziness, sedation, nausea, and vomiting.

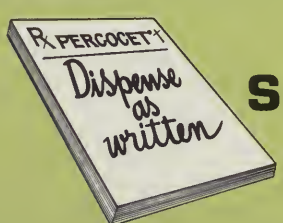
No Patient Should Suffer From Pain

You may avoid pain by providing adequate time-contingent dosing to prevent breakthroughs rather than subduing them[1].
Regular schedule dosing with Percocet may prevent a recurrence of pain[1]. The usual adult dosage is one tablet every six hours as needed for pain.

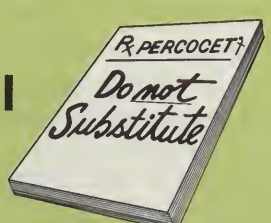
Accept no substitute for PERCOCET®

PERCOCET® C II

(Oxycodone [WARNING: may be habit forming] and Acetaminophen Tablets, USP)



Specify the Original



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Barley Mill Plaza
Wilmington, DE 19880

*Please see brief summary on next page

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Specify the Original

No patient should suffer from pain

RELY ON PERCOCET® TO

(Oxycodone (**WARNING:** May be habit forming) and Acetaminophen Tablets, USP)

CONTROL PAIN.
THE SOONER THE BETTER

REFERENCE:

1. Acute Pain Management Guidelines Panel. *Acute Pain Management in Adults: Operative Procedures. Quick Reference Guide for Clinicians.* AHCPR Pub. No 92-0019, pg. 12. Rockville, Md: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services.

BRIEF SUMMARY

PERCOCET® (Oxycodone (**WARNING:** may be habit forming) and Acetaminophen Tablets, USP)

INDICATIONS AND USAGE PERCOCET is indicated for the relief of moderate to moderately severe pain.

CONTRAINDICATIONS PERCOCET should not be administered to patients who are hypersensitive to oxycodone or acetaminophen.

WARNINGS Drug Dependence: Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of PERCOCET, and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral narcotic-containing medications. Like other narcotic-containing medications, PERCOCET is subject to the Federal Con-trolled Substances Act (Schedule II).

PRECAUTIONS General: *Head Injury and Increased Intracranial Pressure:* The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute Abdominal Conditions: The administration of PERCOCET or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Special Risk Patients: PERCOCET should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

Information for Patients Oxycodone may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using PERCOCET should be cautioned accordingly.

Drug Interactions: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) concomitantly with PERCOCET may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

The use of MAO inhibitors or tricyclic antidepressants with oxycodone preparations may increase the effect of either the antidepressant or oxycodone.

The concurrent use of anticholinergics with narcotics may produce paralytic ileus.

Usage in Pregnancy Pregnancy Category C: Animal reproductive studies have not been conducted with PERCOCET. It is also not known whether PERCOCET can cause fetal harm when administered to a pregnant woman or can affect reproductive capacity. PERCOCET should not be given to a pregnant woman unless in the judgment of the physician, the potential benefits outweigh the possible hazards.

Nonteratogenic Effects: Use of narcotics during pregnancy may produce physical dependence in the neonate.

Labor and Delivery: As with all narcotics, administration of PERCOCET (oxycodone and acetaminophen tablets, USP) to the mother shortly before delivery may result in some degree of respiratory depression in the newborn and the mother, especially if higher doses are used.

Nursing Mothers: It is not known whether PERCOCET is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when PERCOCET is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS The most frequently observed adverse reactions include lightheadedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down.

Other adverse reactions include euphoria, dysphoria, constipation, skin rash and pruritus. At higher doses, oxycodone has most of the disadvantages of morphine including respiratory depression.

DRUG ABUSE AND DEPENDENCE PERCOCET (oxycodone and acetaminophen) Tablets are a Schedule II controlled substance.

Oxycodone can produce drug dependence and has the potential for being abused. (See WARNINGS.)

OVERDOSAGE Acetaminophen Signs and Symptoms: In acute acetaminophen overdosage, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma and thrombocytopenia may also occur.

In adults, hepatic toxicity has rarely been reported with acute overdoses of less than 10 grams and fatalities with less than 15 grams. Importantly, young children seem to be more resistant than adults to the hepatotoxic effect of an acetaminophen overdose. Despite this, the measures outlined below should be initiated in any adult or child suspected of having ingested an acetaminophen overdose.

Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion.

Treatment: The stomach should be emptied promptly by lavage or by induction of emesis with syrup of ipecac. Patient's estimates of the quantity of a drug ingested are notoriously unreliable. Therefore, if an acetaminophen overdose is suspected, a serum acetaminophen assay should be obtained as early as possible, but no sooner than four hours following ingestion. Liver function studies should be obtained initially and repeated at 24-hour intervals.

The antidote, N-acetylcysteine, should be administered as early as possible, preferably within 16 hours of the overdose ingestion for optimal results, but in any case, within 24 hours. Following recovery, there are no residual, structural, or functional hepatic abnormalities.

Oxycodone Signs and Symptoms: Serious overdosage with oxycodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

Treatment: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and the institution of assisted or controlled ventilation. The narcotic antagonist naloxone hydrochloride (Narcan®) is a specific antidote against respiratory depression which may result from overdosage or unusual sensitivity to narcotics, including oxycodone. Therefore, an appropriate dose of naloxone hydrochloride (usual initial adult dose 0.4 mg to 2 mg) should be administered preferably by the intravenous route, and simultaneously with efforts at respiratory resuscitation (see package insert). Since the duration of action of oxycodone may exceed that of the antagonist, the patient should be kept under continued surveillance and repeated doses of the antagonist should be administered as needed to maintain adequate respiration.

An antagonist should not be administered in the absence of clinically significant respiratory or cardiovascular depression. Oxygen, intravenous fluids, vasopressors and other supportive measures should be employed as indicated.

Gastric emptying may be useful in removing unabsorbed drug.

DOSAGE AND ADMINISTRATION Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. PERCOCET (oxycodone and acetaminophen tablets) is given orally. The usual adult dosage is one tablet every 6 hours as needed for pain.

HOW SUPPLIED PERCOCET (5 mg oxycodone hydrochloride and 325 mg acetaminophen tablets, USP), supplied as a white tablet, with one face scored and inscribed PERCOCET, and the other inscribed with DuPont name is available in:

Bottles of 100	NDC 0590-0127-70
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Hospital Blister Pack of 25 (in units of 100)	NDC 0590-0127-75

Store at controlled room temperature (15°-30°C, 59°-86°F).

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6365/August, 1994

Speak Out

Health system reform: heeding the lessons of history

Excerpts from the Med Chi 1994 Semiannual Meeting keynote address

How we got to where we are

Medical school accreditation. Health system reform in this country began in 1910 with a remarkable document called the "Flexner Report." Named for Abraham Flexner—an educator who preceded Albert Einstein as director of Princeton University's famous Institute of Advanced Studies—the report reviewed every medical school in the United States and found that many were run as for-profit organizations, primarily benefitting the people running the school. They often taught anatomy without cadavers, pathology without microscopes, and medicine and surgery without hospitals and clinics. As a result, a standard was established to accredit medical schools throughout the United States. Overnight, 29 medical schools closed because they did not meet the standards. For the first time, medical education in the United States had a high and uniform standard to follow.

Health insurance, fringe benefits. The next step toward reform involved school teachers in Texas who each put 80 cents a week into a pool that would be available to provide for their health care if they ever got sick. This was the beginning of what eventually became the Blue Shield program.

Then, during World War II, it became important to reward workers for their enormous productivity without breaking the country's rigorous wage and price controls. This inspired the concept of fringe benefits, and health insurance came to be part of the fringe benefit package that employees received as part of their employment. Today, this is how 80% of the people under age 65 have their insurance.

Cost becomes a factor. After World War II, third party insurance expanded enormously, followed in the 1960s by Medicare. The programs were so big and so successful that most people found they could get most of the care they needed most of the time without having to worry about finances. But starting in the mid-1970s, as health care costs began spiralling upward, we began to see that cost was as critical an issue as quality and access. Now that concern has become a perception of crisis. It began in 1990 with two seemingly unrelated events just to the north of Maryland.

On the west side of the Delaware river, in Pennsylvania, Republican Senator John Heinz was killed in a helicopter accident. A special election was

Speak Out

held to fill his unexpired term. Dick Thornburgh, the former Republican governor of Pennsylvania who had become U.S. Attorney General, was expected to win, but he ran a terrible, lackluster campaign, refusing to address the issues. The Democrat, Harris Wofford, came out of nowhere and was underrated by the Republicans. He aired one fabulous commercial that said, "If every criminal deserves a lawyer, every sick person deserves a doctor." Wofford created the impression he was ready to address reform, and he won a stunning upset.

On the other side of the Delaware River, Democratic Governor Jim Florio had raised taxes to balance the budget. It was a fatal mistake. That same election day, the state legislature in New Jersey went from two-thirds Democrat to two-thirds Republican. The message was clear. The public was demanding that the issues of health system reform be addressed, but not by raising taxes.

Financing health care

There basically are two ways to finance health care: pay for health care as a fringe benefit of employment or by taxes. Five taxes are available: income, sales, property or real estate, cigarette and alcohol, and payroll tax paid by the employer. The first three—sales, income, and property or real estate taxes—politically are dead on arrival. The public absolutely refuses to raise these three taxes sufficiently to cover the cost of health care. Second: You cannot generate enough money to pay for health care from cigarette and alcohol taxes, no matter how high they go. That leaves only the payroll tax paid by employers, which means the business community pays for health care through an employer mandate or a payroll tax. No bill before Congress talks about any realistic funding source other than one that is employer based.

Clinton's promise. That brings us to 1992, when President Bush forgot all about the lesson of the Pennsylvania election of 1990—if he ever learned it in the first place. President Bush ran his version of Thornburgh's race all over again, and with the same result. He refused to address the economy and health care—two of the reasons why Governor Clinton won the race. And you must give him credit, whether you like him or not. He ran an absolutely brilliant campaign. He came in stating he was going to propose health system reform in the first 100 days of his administration. What happened next was a series of mistakes and tragedies.

The mistakes, part one. First, he lost control of the process very early on. It was a mistake to put his wife in charge of health system reform. I have met with her on several occasions; she is an extremely brilliant woman. She knows health care issues by studying the issues herself. If Mr. and Mrs. Clinton were not married they would not be political allies. He is a typical moderate southern Democrat, a states' rights advocate, a governor. She is an

arch liberal federalist. They are like Jefferson and Hamilton and they are not going to agree on any basic issue of health policy.

Health system reform is not the most difficult thing in the world to do, but, it certainly seems like the most complex. It is not like having two sides and you can achieve a balance point. Health system reform has 10 sides, and every issue has to take many factors into account. Washington in 1992 failed to do that. We needed an open process with experts in delivering health care, patients who receive the care, and both political parties in Congress who have to decide how to pay for health care. It had to be an open process, it had to be done in the first 90 days, it had to be a 40-page bill and it had to be before Congress by Easter of 1993. If that had happened, reform would have passed.

We only needed four things: insurance reform with no exclusion for preexisting conditions; community rating; portability of coverage; and an employer mandate.

Why an employer mandate? The employer mandate is the core of any successful, nongovernment-run health care delivery system. This is a practical, not a political, fact of life. Twenty years of experience in Hawaii proves it can work. Doctors do well, patients do well, businesses do well. Health insurance is 30% cheaper than in almost any other state in the country.

An experience in New York also confirms that reform can work. But not how you might think. New York proved what *won't* work.

New York passed insurance reform with no exclusions for pre-existing conditions and community rating—without a mandate—and it has been the disaster the state medical association predicted. The sick and the bad risks quite naturally bought insurance because they pay the same as healthy young people. But young people, as a result of the price going up 25% in a year, decided not to buy health insurance at all—until they get sick, that is. So, young, healthy people are dropping out of New York's insurance pool, sick people are buying in at low prices, and the rates are skyrocketing as a result. Here is why the employer mandate becomes important. It requires young, healthy people to buy insurance, thus driving down the cost of care. This probably is the most significant cost containment device that we can have.

The cost of cost containment. Everybody wants cost containment, but no one wants to do the things to contain costs. In a recent interview I was asked, "What's your program for cost containment?" I answered that I have a proposal that would save $150 billion a year in health care reform, but I cannot get anybody in either party to introduce it.

This is what it is: no tobacco, no drunk driving, seat belt ignition interlock (where your car won't start unless your seat belt is locked), nobody overweight, and everybody exercise every day and eat a high fiber diet.

Well, that was the end of the interview because no one is interested in that.

Similarly, when told the employer mandate is essential to contain costs, people reject it on ideological grounds.

We have to decide on which agenda we are going to work. I am not interested in working anybody's liberal or conservative agenda. I am interested in working the agenda that will give us the changes we need.

The mistakes, part two. That brings us to the present—and to the big question: What really happened in Washington? Well, somebody apparently thought that we were dealing with the Manhattan Project. Reinvent the atomic bomb and don't let the Russians find out. The Administration decided to do health system reform in secret.

Now we are learning that they operated in a vacuum, with mostly government employees. As a result, they didn't have people who could communicate to the rest of us what they were talking about. The strangest things happened. A managed competition bill was written by single payer advocates. The proposed tort reform followed California's example, but left out the key element that makes it work—a $250,000 cap on pain and suffering.

Those secret committees were led astray simply because they lacked any real experience. Eventually they came up with a document 1,342 pages long, loaded with bureaucratic controls and unnecessary details, with mistake, after mistake, after mistake.

They missed the lessons of history. Never has a major piece of legislation passed in this country that was so lengthy. The Social Security Act was 82 pages; Medicare was 119 pages.

No major piece of social legislation has ever passed that included all details and spelled out all bureaucracies.

They also took too long to do it, giving the opponents time to organize. The Chamber of Commerce had time to switch from support for an employer mandate to opposition. The insurance industry had time to put Harry and Louise on the air. And the President had to use all of his political ammunition protecting unnecessary details, rather than focusing on the core of his plan.

The architects of that document took the President's ideas and converted them into a bill that no one could support. They are almost single-handedly responsible for the fact that we do not yet have any health system reform legislation today. Their lack of experience killed the President's health care reform proposal.

The AMA's role

In 1990, the AMA introduced a set of principles of health system reform called "Health Access America." We made a strategic decision that was very controversial at the time, although time has proven it was correct.

The decision? To advocate our principles and not introduce a full-blown bill of our own. The rationale? To have the freedom to weigh each legislative proposal against our principles, without asking people to be either for or against our own bill. This provided neutral ground and kept every door in Washington open to us. Not until late summer did we even suggest support or opposition for any single legislative package.

Our principles included:

- an employer mandate, along with government subsidies and individually purchased insurance;
- protections for small business;
- insurance and tort reforms;
- a realistic cost containment package.

Many AMA principles appeared in the President's proposal. But his plan also added unnecessary extras like purchasing alliances and bureaucratic controls while failing to deliver on tort reform. It became evident that the President's proposal was fatally flawed by the tremendous amount of government control. There was so much opposition, there was no chance of its passing.

Then Mr. Gephardt in the House and Mr. Mitchell in the Senate introduced shadow versions of the President's proposal. The AMA evaluated both and took positions of nonsupport. I know there is a perception we supported the Gephardt bill. Nothing could be further from the truth, especially when it came to tort reform. The Gephardt bill actually made things worse, and the Mitchell bill was nothing more than a stalking horse for the trial lawyers association.

We did endorse a bipartisan bill in the House originally known as the Rowland-Bilirakis bill, despite its shortcomings. The bill lacked an employer mandate, but did provide adequate cost containment, good tort reform, and good antitrust relief. It also incorporated provisions of the AMA's Patient Protection Act, on which we could ingraft a mandate in the future.

Eventually we will have to deal with universal coverage. The only way to achieve it is with a mandate of some sort. But that appears politically dead in the water. And that leaves a need vastly unmet.

What about the single payer system?

We need to recognize that this is the United States and not Canada. There are fundamental differences. Every westernized country with a single payer has a parliament. This guarantees that executive and legislative control is in the same party. You don't have the give and take that is built into our government. This is an absolutely crucial point. Everyone claims an American single payer system will be just like Canada's. Not true. Most U.S.

Speak Out

proposals keep the insurance companies and HMOs as intermediaries, not to be done away with.

Secondly, compare the two countries. Key dynamics are very different. Canadian malpractice rates are one-sixth what they are here because there are no awards for pain and suffering. Losers pay the winner's legal fees and there are no contingency fees for lawyers. Hospital capital expenditures are provided by the government. Hospitals get interest-free mortgages, enormously impacting the hospital's overhead and costs. Canada funds medical education separately. Students graduate with virtually no debt because tuition is $1,000 or less. The cost of medical education is not included in health care costs nor is the cost of medical research. Canada has a smaller percentage of people over 65, which lowers health care costs. There is virtually no inner city drug traffic, crime, or teenage pregnancy in Canada compared to the United States, and that also impacts costs.

How does Canada fund its health care? A quarter of the taxes collected go for health care. Americans pay an average of 27% in combined state and federal taxes. Canadians pay 49%. In Quebec the sales tax is 15%; gasoline is $3.50 per gallon; cigarettes are $5.50 per pack; beer is $6.00 a six pack. You cannot deduct mortgage interest from your taxes.

Give me that tax structure in the United States and devote one-quarter of all of the taxes collected for health care and then I'll be willing to sit down and talk about a single payer, government-funded, taxed-based system. But don't try and lie to me and tell me that we can have those benefits on our tax structure. It just doesn't work.

Unfortunately, the history of tax-based funding for health care in this country is not Canada, it's Medicaid, and that is based on the principle that I refer to as the "unholy trinity of health care"—over-promise, under-fund, and shift the blame. The AMA opposes single payer proposals because they are not adequately funded and they fail to address the infrastructure and overhead cost of the delivery of medical care. We are just as concerned about the cost of care as anybody. Nine percent of what Americans spend on health care ends up as physician income. *Nine cents of every health care dollar.* We recognize that we will have to give up part of our nine percent. But you won't solve all the problems by concentrating on that nine percent and ignoring the other 91%.

What's next?

Several years ago, the AMA sent a delegation to England to evaluate its national health service. One of the people who spoke to us was a gentleman who held the position in Parliament that corresponded to Henry Waxman's position in Congress. His last name was Miller and he told us he had

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developed Miller's Laws for health care run by the government. Miller's Laws are:

1. No central planning. Make all at the local level.
2. Physicians and hospital administrators with real experience treating patients and running hospitals must be involved in policy making.
3. The process must be open and not become a political football.

The Clinton plan could never measure up to Miller's Laws. I hope we will now begin to see a pragmatic, honest approach to the problem without dealing with issues of desperation. The upcoming Congress will be very different from what we have now; it's unlikely that any bill out of the White House will get passed in the next two years. It also is unlikely that Mr. Clinton will get reelected. Unfortunately, I believe it will be several years before we get comprehensive reform.

People have a right to the health insurance they need. If you look back to the 1960s, there were two perceived needs: the poor and elderly. Medicare and Medicaid met those perceived needs in the minds of most people and things survived. The system as we know it will continue to evolve and modify if we meet the perceived needs of the public. If we do not meet their needs, we will begin to see some very, very radical change, but not within the next two years.

RICHARD E. CORLIN, M.D.
Dr. Corlin is vice speaker of the American Medical Association House of Delegates. ■

Share your opinions

The Editorial Board of the *Maryland Medical Journal* encourages Med Chi members to share their opinions, beliefs, and convictions about all aspects of medicine. Letters to the Editor and essays for *Speak Out* should be sent to Editor, *Maryland Medical Journal,* 1211 Cathedral Street, Baltimore, MD 21201-5585.

LETTERS TO THE EDITOR

CME requirements for Maryland medical license renewal

I am writing about an article that appeared in your July 1994 issue called "Maryland medical license renewals, 1994: continuing medical education requirements."[1] The article includes several inaccurate statements. I cannot tell from the article whether the fault lies in the Maryland requirements themselves or in the interpretation of the requirements.

The article states that "credit hours are authorized by the Accreditation Council for Continuing Medical Education." The ACCME is one of the organizations that accredits organizations for continuing medical education, as do state medical societies. ACCME does not approve individual CME activities and does not "authorize credit hours," whatever the phrase means.

The article suggests that medical schools accredit. They do not do so. Medical schools are accredited by ACCME. They provide CME activities and designate those activities for credit. The article includes a badly muddled paragraph about Canadian CME. I think that what physicians in Maryland need to know is that they can attend Canadian medical school-sponsored CME and claim credit. Contrary to what I understand the article to say, professional societies in Canada can join with medical schools and provide education that is acceptable for AMA PRA [American Medical Association Physician's Recognition Award] Category 1 credit. ACCME-accredited sponsors can designate activities provided abroad for AMA PRA Category 1 credit. And the AMA has a procedure for providing Category 1 credit for international conferences; the details about this procedure are provided in the AMA PRA information booklet.

From my reading, the article does not distinguish between credit allowed by the Maryland licensing board and that allowed by other agencies. I gather that Maryland will accept credit for education in acupuncture and up to ten hours of undocumented education toward specialty board certification. The AMA would not accept education in acupuncture and would not allow AMA PRA Category 1 credit for undocumented CME activities. I suspect that most other certifying organizations also would not do so.

The article, perhaps because of the wording of the Maryland licensing board requirements, confuses terminology. It uses "designated" and "accredited" incorrectly. For the record, organizations are "accredited" to provide continuing medical education. Accredited organizations are able "to designate" credit for continuing medical education courses.

The author of the article gives one piece of excellent advice, that is that physicians should examine CME course announcements carefully. The AMA provides that courses designated for AMA PRA Category 1 credit or AMA PRA Category 2 credit should make use of standard words, as follows: "The (name of accredited sponsor) designates this continuing medical education activity for ( ) credit hours in Category 1 (or Category 2, as applicable) of the Physician's Recognition Award of the American Medical Association." Different designation statements are used by other organizations,

particularly by the American Academy of Family Physicians. But as the author recommends, a physician reviewing material about a course before enrolling should be certain that there is an appropriate statement clearly designating the activity for credit and indicating exactly who the sponsor is, as well as the kind and amount of CME credit provided.

I certainly hope that the editors will review the article in question and provide exact information for physicians in Maryland.

ARTHUR M. OSTEEN, PH.D.
Director, Office of Physician Credentials and Qualifications
American Medical Association

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Dr. De Hoff replies

We are grateful that Dr. Osteen has carefully clarified the differences between authorization, accreditation, certification, designation, and acceptability of CME credits. This should help physicians to better understand decisions of the several official groups that are working to improve CME's efficiency and efficacy. He has also called attention to the various names and listings for CME credit used by other certifying agencies or societies, which can confuse physicians or licensing bodies.

Comments about the Physician's Recognition Award or what learning experiences are or are not acceptable for the PRA were not germane to licensure. The AMA PRA, valuable though it may be, is not itself acceptable for license renewal purposes in Maryland. Certificates of valid Category 1 CME credits included in applications for PRA can be used to meet license renewal requirements if they were obtained within the 24 months preceding the renewal application. Also, the Board of Physician Quality Assurance has elected to allow CME credits for education in acupuncture and self-instruction for board certification, decisions that do not require AMA or ACCME acquiescence.

Our article was intended to help physicians meet license renewal requirements, not to describe in detail the complex and often bureaucratic chains that control CME awards. Frank Davidoff, of the American College of Physicians, recently described CME in the United States as "pre-Flexnerian."[1] He further stated that control is split between the seven independent medical associations that created the ACCME and the AMA. One consequence has been an excessive focus on process rather than educational or clinical effectiveness.

Obtaining an arbitrary number of CME "credit hours," required for license renewal and in some cases, hospital privileges, can turn into a numbers game in which neither quality of medical education obtained nor improvement in professional practice is considered. Present efforts at AMA and ACCME and elsewhere are reported to be turning toward improving learning processes and the quality of practice that results from CME.

Physicians should identify what they need to learn to improve their professional skills and then tailor their choices of CMEs to those requirements. Instructional formats are gradually chang-

ing to involve physicians in learning process, no longer to be passive auditors of formal lectures. Methods to measure and account for the values of effective self-instruction must be devised. A new element, continual professional development (CPD) has been added to practice improvement. CPD includes allied or peripheral learning experiences that contribute to a total medical practice but which are not necessarily medical in content.

Teachers also must be taught so that what they teach measurably improves patient care quality. Moreover, all providers must recognize that the total costs of any CME experience are high, especially when absence from practice and expenditures for temporary replacements ("locums") are added to charges for courses, subsistence, and travel.

JOHN B. DE HOFF, M.D.
Staff Medical Consultant
State of Maryland Board of Physician Quality Assurance

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Letters To The Editor

The editorial board of the *Maryland Medical Journal* welcomes comments, criticisms, recommendations, and observations from all its readers. Please submit letters to

Editor
Maryland Medical Journal
1211 Cathedral Street
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The man who mistook his doc for a cat

Touch me; it's so easy to leave me all alone with my memory of my days in the sun (From the musical "Cats").

Careful *JAMA* readers will have noticed the editorial[1] in which a physician described how she "cured" a 95-year-old patient of his predilection for inappropriately touching female caregivers. Several home health nurses had refused to continue caring for him because he would not keep his hands to himself. He had been scolded and warned, but the behavior worsened, including two incidents involving his physician. Astutely judging that the patient needed something safe to fondle, the physician prescribed a cat. Not only did the animal prove to be an acceptable tactile alternative for the patient, it gave him a topic of conversation other than his health, thus heightening the ability of friends and relatives to enjoy their visits with him.

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1. Fisher LA. The last of August. *JAMA* 1994;272:1310

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Evaluation and conservative management of women with stress urinary incontinence

Rene R. Genadry, M.D., F.A.C.O.G., F.R.C.S.(C)

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ABSTRACT: *Urinary incontinence can be a social and practical problem. A complete evaluation correlating the history, physical examination, and screening studies confirms the syndrome and its significance, leading to the therapeutic management most appropriate for the individual patient. Although long-term cure can be effected by surgery, conservative measures are available and effective depending on the degree of dysfunction and the motivation of the individual patient.*

Urinary incontinence is involuntary urine loss that may occur under variable circumstances. Episodes may be associated with a strong urge to void, as seen in urge incontinence (UI), or be due to a sudden increase in intra-abdominal pressure, as occurs in stress incontinence (SI). Incontinence also may occur with a relative urethral obstruction or a neurogenic bladder, which are often associated with voiding dysfunction and overflow incontinence. Post-void dribbling is often seen in patients with a suburethral diverticulum. Patients with extra-urethral incontinence including fistula experience continuous incontinence and enuresis.

In its mildest form, urinary incontinence is a common occurrence among women. It can become a problem when it interferes with the patient's hygiene and normal daily activities. Prevalence increases with age; incontinence has been reported in 5% of female college students, in 10% to 25% of women aged 15 to 64,[1] and in up to 50% of elderly women.[2] UI and bladder dysfunction are more common in the latter, while SI occurs more often in younger women.

Clinical evaluation

In patients with SI, the most common differential diagnosis is anatomical SI and UI. In patients with severe incontinence, the differential diagnosis also

should include urethral sphincteric dysfunction and iatrogenic causes of incontinence. Thus, the pathogenesis of the most common form of urinary incontinence includes lack of anatomical support, presence of bladder dysfunction, and/or any altered urethral sphincteric function or anatomy as seen in a damaged urethral sphincter following surgery or denervation. Evaluation of patients with incontinence should include the clinical history, physical examination, and various specific investigations.

History. The initial and most important aspect of the evaluation is the history. The patient should be allowed to describe her symptomatology, including duration, severity, type, and degree of functional disability. The history also should focus on the circumstances associated with the urine loss.

In patients with SI, incontinence occurs with exertion (e.g., coughing, sneezing, laughing, walking, jumping). They tend to report losing urine in variable amounts and independently of the volume of urine in the bladder. There usually are no other symptoms of bladder instability. Voluntary frequency is rarely reported as a means to avoid the embarrassment of urine loss.

Patients with UI usually report feeling the urge to urinate at the time of the urine loss. The feeling usually overcomes their ability to remain continent until they reach the bathroom facility. They are likely to report losing a large volume of urine or an almost complete emptying of the bladder. Severity could be assessed by objective means, such as pad counting and frequency of the need to change clothes.

Patients with overflow incontinence are likely to report a constant feeling of fullness or suprapubic pressure, enuresis, and dribbling, which at times is exacerbated by physical stress. Patients with a suburethral diverticulum typically report dribbling after completion of urination. Those with fistula complain of continuous incontinence, including diurnal and nocturnal enuresis.

The circumstances surrounding the onset of the incontinence may help determine its etiology. In patients with SI, onset is often related to delivery of the first child, with improvement in the interim periods between pregnancies and exacerbation during subsequent pregnancies and deliveries. In patients with UI, a trigger event (laugh; key to lock; sight or sound of water) and a higher incidence of childhood enuresis is usually found. When the onset of incontinence follows a surgical procedure or radiation therapy, the possibility of a fistula or a denervated, nonfunctional urethra should be considered.

Other symptoms of urinary dysfunction (including frequency, nocturia, dysuria, hematuria, enuresis, and difficulty voiding) should be noted. Relevant medical, psychiatric, and neurologic disorders should be elucidated, as well as possible pharmacologic causes of transient incontinence. Patients should be asked about the presence of fecal incontinence, particularly if they are elderly or a neurogenic component is suspected.

Physical examination. The physical examination should be methodical and thorough, including a general examination and a dedicated pelvic and neurologic examination. Examination of the pelvic floor should assess overall pelvic support, support of the anterior compartment, and mobility of the vesical neck. Vaginal estrogen effect should be assessed, as well as the type and degree of relaxation of the vaginal walls. During the neurologic examination, perineal and perianal sensations and anal sphincter tone and contraction should be tested. The anocutaneous and bulbocavernosus reflexes, as well as the knee and ankle jerk, should be elucidated and the integrity of the sacral arc reflex should be confirmed. Any abnormality justifies a complete neurological examination.

At the completion of the examination and after the patient has emptied her bladder completely, a catheter should be used to check the post-void residual. This is an important step in ruling out the possibility of overflow incontinence and urinary tract infection.

The catheter also can be used to indicate bladder neck hypermobility. The angle of the catheter with the horizontal at rest is compared to the angle during Valsalva. Any deflection over 30 degrees indicates a poorly supported bladder neck.

With the catheter in place, the patient's bladder can be filled for a stress test that is carried out in both the supine and erect positions. The patient is asked to inhibit voiding while coughing and bearing down. The urethra in full view confirms the diagnosis of a transurethral loss of urine. The relationship between the loss of urine and the stressful event is also noted; delay could indicate a stress-induced bladder contraction. In the standing position, the patient is asked to heel bounce and listen to running water; this provocative testing facilitates development of such contractions.

To complete the initial evaluation, the patient is asked to keep a diary to assess the severity of the incontinence and the circumstances of the urine loss. The diary can also provide information about the functional capacity of the bladder and the presence of any elements of bladder dysfunction. The patient should be asked to time and measure her liquid intake and urine output. Any leakage and the circumstances surrounding it should be noted.

In patients whose histories indicate SI with no evidence of bladder irritability, minimum testing should include a cystometrogram (CMG). This can be carried out by placing in the bladder a red rubber catheter connected to an aseptic syringe held in the vertical position at the level of the symphysis pubis. The syringe is filled in 50 cc increments and the water level is checked for any abnormal fluctuation indicative of bladder contraction while the patient is instructed to avoid Valsalva. In patients with suspected bladder instability, a standing multi-channel CMG may be needed to unmask it.

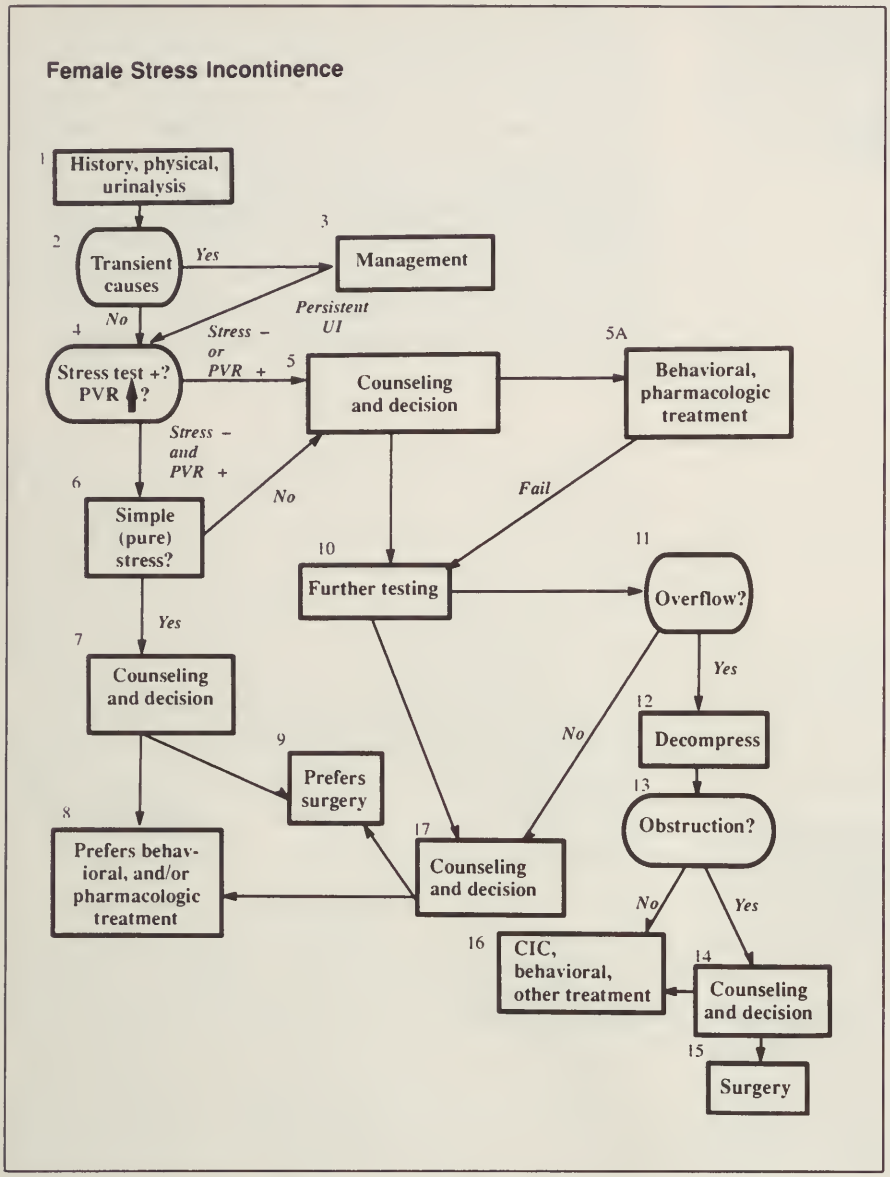


Figure 1. Female Stress Incontinence

In patients who have a poorly supported bladder neck but a normally functioning detrusor muscle as indicated by a normal CMG, a urethral pressure profile in its static and dynamic forms can provide additional information. Although the significance and accuracy of the urethral pressure profile is controversial, it does provide important information about the presence of a low-pressure urethra. Indeed, low closure pressure has been associated with lower cure rates. In addition, a dynamic profile can support the diagnosis of stress incontinence by confirming the presence of negative closure pressure at the time of leakage. The evaluation should help the physician differentiate among an unstable bladder, stress urinary incontinence, and/or overflow incontinence as the diagnosis.

Clinical management

The most valuable information available to date for the evaluation and management of patients with urinary incontinence is summarized in the Clinical Practice Guidelines on Urinary Incontinence in the Adult published by the Agency for Health Care Policy and Research.[3] The algorithms for the management of patients with SI and UI provide a framework for selecting forms of management according to the patient's needs and goals, with the underlying notion "that surgery except in very specific cases should be considered only after behavioral and pharmacologic therapies have been tried" (**Figure 1**).[3] Although recognizing that some patients are initially candidates for surgical correction of a hypermobile but otherwise normally functioning urethral sphincter, the guidelines recognize that minor complaints in some patients who are not candidates for surgery can be managed by alternative therapies aimed at enhancing the compensatory mechanisms involved in urethral continence. A significant role in that respect befalls the mucosa, submucosa, smooth musculature, striated musculature, and urethral position and support. Medical therapy, physical therapy, physiotherapy, and mechanical and/or surgical therapy are some of the means available to affect and enhance their respective contribution to continence (**Table 1**).

Proper management of SI should take into account the disability that the condition causes the patient as well as the anatomical disruption that is the cause of the condition. When advising patients and recommending the proper form of therapy, physicians should formulate subjective and objective treatment goals. They also should remember that for some patients success is not equated with complete dryness and that treatment goals are often relative to the individual concerned and cannot be superimposed.

Nonsurgical options for dealing with SI include pelvic muscle exercises, pharmacologic therapy, mechanical devices, and functional electric stimulation.

Pelvic muscle exercises. These are specific exercises to strengthen the pubococcygeal muscle and related fibers that play a compensatory role in increasing urethral pressure. An 80% subjective cure was reported in Kegel's series of 500 patients.[4] Wells and associates[5] reviewed 22 studies with reported cure rates of 31% to 73% and successful outcomes of 38% to 93%. Although the studies used different outcome

Table 1. Common causes of transient incontinence

- ❒ Infection
- ❒ Atrophy (atrophic vaginitis/urethritis)
- ❒ Drugs
  - *sedatives*
  - *diuretics*
  - *anticholinergics*
  - *alpha-adrenergics*
  - *calcium channel blockers*
- ❒ Psychological
  - *severe depression*
- ❒ Excessive urine production
  - *hypercalcemia*
  - *hyperglycemia*
  - *diabetes insipidus*
  - *CHF*
  - *low albumin status*
- ❒ Restricted mobility
  - *arthritis*
  - *Parkinson's disease*
- ❒ Stool impaction
- ❒ Delirium (confusional states)

measures, at least one third of the patients were reported cured in the absence of surgical treatment. In one study, 47% of the patients avoided surgery because they viewed their condition as cured or improved after three months of intensive pelvic floor exercises.[6]

Of critical importance in all of the successes with pelvic muscle exercises is the ability of the patient to identify her pelvic floor muscles and to perform the exercises daily. We recommend 10 to 20 contractions held for 5 to 10 seconds each, performed in various positions, 6 times daily for 6 weeks, followed by maintenance of 3 times daily. It is usually important to start patients with some form of biofeedback (e.g., perineometer, vaginal cone, or simply the patient's fingers). In 3 studies involving a total of 103 patients, 68% to 79% noted cure or improvement after 4 to 6 weeks of regular use of vaginal cones.[7-9] Patient education regarding ultimate goals, purpose of the exercises, and what is being measured are the most important factors in the motivation and proper performance of successful pelvic muscle exercise programs.

Pharmacologic treatment. Studies of hormonal and sympathetic modulation of urethral function have included the use of estrogens, alpha-adrenergic receptor agonists, beta blockers, and the tricyclic antidepressant imipramine. Available data indicate that a combination of modulating substances is more effective than any substance used singly. In studies involving phentolamine/estriol and norpramine/estradiol, cure rates of 15% to 64% have been reported.[10,11]

Mechanical devices. These have not been extensively studied.[12] Limited data suggest that a contraceptive diaphragm may provide additional support to the posterior wall of the urethra, thus reducing its field of excursion.[13] Functional electric stimulation to augment urethral sphincteric function and inhibit bladder contractility has not gained wide acceptance in this country. Nonetheless, in a prospective study of 55 SI patients scheduled for surgery, 56% were reported able to avoid it with the use of electric stimulation.[14] Factors associated with success included patient motivation and no prior surgery.

Conclusion

Surgical management of genuine SI relies on the two elements of urethral function and support. If this function is maintained, any procedure that allows proper support for the posterior urethral wall will achieve continence. In the absence of normal urethral function, the support must be supplemented by compensatory procedures (e.g., urethral injections, slings, artificial sphincters).

Conservative management of SI is noninvasive, carries minimal risk, and is less expensive than surgery. It is indicated for patients who do not want or are poor candidates for surgery and for those who have only slight or occasional symptoms that require intermittent intervention.

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Results of a recently reported placebo-controlled trial indicate that electrical pelvic floor stimulation may significantly improve both subjective and objective measures of urine leakage in women with genuine stress incontinence (GSI).[1] Peter K. Sand, director of the division of urogynecology at Northwestern University School of Medicine in Chicago, reported the study findings at the annual meeting of District VI of the American College of Obstetricians and Gynecologists.

The prospective, 12-week, randomized, multicenter study initially enrolled 52 women with GSI who had no other cause of urinary leakage and who had never been treated with electrical stimulation. Thirty-five subjects were assigned to active treatment (a dual-frequency electrical stimulator) and 17 to a placebo device. Subjects used the device 15 minutes twice daily for 4 weeks, then twice daily for 30 minutes. During the 12-week study, 9 active and 4 placebo patients dropped out. Subjective outcome data were obtained from patient-kept voiding diaries. Objective data were obtained by comparing pre- and post-activity weights of sanitary pads.

Of the 26 active-treatment subjects who completed the trial, 7 (27%) were considered cured by objective data and none were considered cured by subjective data. However, 16 (62%) improved 50% or more according to pad tests and 13 (50%) improved by at least 50% according to the diary. Of the 13 control subjects, only 3 (20%) improved 50% or more by objective measures, and only 2 (12%) improved at least 50% by subjective measures.

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Correlation of thyroid histopathology with fine needle aspiration of thyroid nodules: the St. Agnes Hospital experience

Carminia Davidsohn, M.D., Cho Cho, M.D., Jean Colandrea, M.D., and George Lawrence, M.D.

ABSTRACT: *Fine needle aspiration (FNA) cytology results were compared with thyroid tissue pathology reports in 44 patients who underwent thyroidectomy. Benign (12) and malignant (10) thyroid cytology interpretations correlated with the final thyroid histopathology. Of 22 thyroid aspirate samples that were considered suspicious or indeterminate, 5 were malignant and 17 were benign. The data obtained support the efficacy of FNA in the evaluation of thyroid nodular disease.*

At the time this paper was written, Dr. Davidsohn was a resident at St. Agnes Hospital in Baltimore, Maryland. Dr. Cho is a second-year resident, Dr. Colandrea is a cytopatholigst, and Dr. Lawrence is chief of endocrinology at St. Agnes Hospital. Dr. Lawrence is also a clinical assistant professor of medicine at the University of Maryland School of Medicine.

Thyroid nodules are a challenging diagnostic problem. Although they are common, apparent thyroid cancer—the principal concern for both patient and physician—is uncommon.[1] Fine needle aspiration (FNA) of the thyroid has increasingly been accepted as a valuable diagnostic aid in the evaluation of thyroid nodular disease.[2-4] The overall reported accuracy of aspiration cytology varies from 50% to 97%[5-7] depending on the experience of physicians performing FNA, the experience of pathologists reading the smears, and the inherent difficulties in differentiating adenomatoid goiter from macrofollicular adenoma and follicular adenoma from follicular carcinoma.

The current chart review study was undertaken to determine correlation between the results of thyroid FNA and tissue pathology from patients with thyroid nodular disease treated at St. Agnes Hospital (SAH) in Baltimore, Maryland.

Methods

Patients. Of 138 patients identified as having undergone thyroidectomy at SAH between January 1989 and December 1992, hospital records were available for 118. Of these, 50 patients (47 women, 3 men) had an FNA performed at SAH. Patients' mean age was 52 years (range, 27 to 77 years).

Reprints: *George Lawrence, M.D., Division of Endocrinology, St. Agnes Hospital, 900 Caton Ave., Baltimore, MD 21229*

Table 1. Cytology diagnoses

- **Benign**
  - colloid nodular goiter
  - chronic and subacute thyroiditis
  - hemorrhagic colloid cyst
- **Suspicious/indeterminate**
  - follicular neoplasms
  - oxyphil neoplasms
  - polymorphous lymphoid cells
- **Malignant**
  - papillary carcinoma
  - medullary carcinoma

FNA. All thyroid aspirations were performed on an outpatient basis by an endocrinologist, a general surgeon, an otorhinolaryngologist, or a cytopathologist. In most cases, no local anesthesia was used. Several aspirations were usually performed and material was given to a cytotechnologist who was present during the procedure. Material from each pass was smeared on paired slides; one was air dried and the other was immediately alcohol fixed. The needle was rinsed in either normal saline solution or RPMI (cell culture medium #1640) and cell block was prepared from the rinse. The air-dried and alcohol-fixed smears were stained with modified Romanowski stain and Papanicolaou stain, respectively.

Cytologic classifications were benign, malignant, suspicious or indeterminate (lesions with possible malignant potential), and inadequate. The cytotechnologist who evaluated the smears at the time of aspiration assessed adequacy. Smears were considered inadequate for diagnosis if the specimen had less than 6 tissue fragments with 15 to 20 well-preserved cells per tissue fragment. If less than 6 fragments were present, a repeat aspiration was performed. The same criteria were used to interpret aspirated cystic fluid; if acellular cystic fluid was obtained, the specimen was considered inadequate and repeat thyroid aspiration was requested.

Table 1 shows the cytologic diagnoses included in the benign, suspicious/indeterminate, and malignant categories. The medical records review indicated that when FNA reports were benign, surgery was performed because of large nodules, patient preference, or cosmetic reasons.

Results

Six thyroid aspirate specimens (12%) were considered inadequate. In the remaining 44 patients, 12 nodules (24%) were benign, 10 (20%) were malignant, and 22 (44%) were suspicious. Final histopathologic examination showed that 29 (66%) were benign nodules including adenomas and 15 (34%) were malignant (see **Tables 2 and 3**).

Table 2. Thyroid aspiration results

Result	Number	(%)
Benign	12	(24%)
Suspicious/indeterminate	22	(44%)
Malignant	10	(20%)
Inadequate	6	(12%)

Ten malignancies were diagnosed cytologically and all were confirmed by tissue examination. Of 15 known malignancies (as demonstrated by tissue diagnosis), all had abnormal cytologic results, either suspicious/indeterminate or malignant, giving a 100% sensitivity rate for malignancy. No known malignancy was reported as negative on cytology.

Of the 22 cytology aspirate specimens designated as suspicious, 5 (23%) were malignant, 13 (59%) were benign neoplasms, and 4 (18%) were benign non-neoplastic lesions on surgical examination.

Twelve cases were reported on cytology as benign. Of these, half were benign neoplasms and half were benign non-neoplastic lesions on tissue examination.

Discussion

FNA was pioneered as a diagnostic tool by Soderstrom in Scandinavia.[8] The procedure is safe and can be routinely used on an outpatient basis. We have found the technique to be sensitive in detecting Hashimoto's thyroiditis, colloid nodules, and medullary and papillary thyroid carcinomas. The use of FNA has halved the number of patients undergoing thyroid surgery and in those who do, there is an increased rate of finding thyroid cancer.[1,8] In our series, all malignant cytology specimens were found to have a malignancy at tissue evaluation of the thyroid. FNA also was found useful in the evacuation and management of thyroid cysts.

Table 3. Correlation of cytopathology and histology results

Cytology	Histology			
	Malignant	Benign Neoplasm	Benign	Total
Malignant	10	0	0	10
Susp./Indeter.	5	13	4	22
Benign	0	6	6	12
TOTAL	15	19	10	44

There are three limitations to FNA of thyroid nodules. First is the difficulty in obtaining and defining an adequate aspirate sample. Medical literature reports indicate that the percentage of inadequate specimens varies from 7% to 17%. The number decreases with both the experience of the person performing the aspiration and the immediate assessment of the aspirate by a cytologist who should be present during the procedure. In the present study, six (12%) aspirate specimens were considered inadequate for cytologic diagnosis. Acellular cystic fluid is also considered inadequate for diagnosis because its presence does not predict benign or malignant disease. Approximately 17% of such specimens have been associated with a final histological diagnosis of malignancy.[9] Repeat thyroid aspirations are recommended to obtain cellular material or to evacuate the cyst permanently.

A second limitation of FNA is the difficulty in differentiating between a nodular goiter and benign follicular neoplasia. The cytologic separation of these entities involves a spectrum of histologic changes that include cellularity, presence and amount of colloid, configuration of tissue fragments, nuclear size, chromatin pattern, and the presence of nucleoli. Some follicular neoplasms (especially macroadenomas) may have an identical cytologic presentation to a nodular goiter. This may explain why half the benign cytology results in the current study were found to be benign follicular adenomas on histologic examination.

A third limitation of FNA is that primary follicular neoplasms cannot be identified as benign or malignant on the basis of cytologic analysis alone. Follicular neoplasms usually exhibit microfollicles (i.e., small amounts of dense colloid and nuclear atypia). Follicular carcinomas, like adenomas, are often well circumscribed and sharply demarcated from adjacent parenchyma in many areas. By definition, follicular carcinomas are only identified by histologic invasion of the capsule or vessels by malignant cells after surgical excision of the nodule.[10] Hürthle cell neoplasms are morphologic variants of follicular tumors and therefore subject to this same limitation. As with follicular lesions, Hürthle adenomas are usually impossible to differentiate from carcinoma on cytologic examination alone. When the cytologic criteria for follicular neoplasms are fulfilled, these cytology specimens are then regarded as suspicious.

Of the lesions that are cytologically considered as suspicious or indeterminate only, 20% to 40% are ultimately found on pathology examination to be malignant neoplasms, 30% to 40% are benign follicular adenomas, and 30% to 40% are non-neoplastic.[11] In our small series, 44% of all FNAs were considered suspicious/indeterminate—an increased proportion compared with the literature—probably because we excluded benign cytology aspirations in patients who did not have thyroid surgery. In our suspicious cytology category, 23% were carcinomas, 59% were follicular adenomas, and 18% were non-neoplastic (colloid and adenomatoid nodules).

Because of the uncertainly in the suspicious/indeterminate category, clinicians may differ in their clinical management of such patients. Some surgically remove the nodules (particularly in patients at high risk for cancer) and others use suppressive doses of thyroid therapy in an attempt to shrink or prevent further growth of the nodule.[12,13]

The current study findings suggest that a benign or malignant thyroid cytology report correlates well with similar results following pathologic review of excised thyroid tissue. This supports the notion that FNA is an important diagnostic tool in the initial evaluation of nodular disease. A suspicious/indeterminate cytology report, however, still leaves doubt as to the true nature of the underlying pathologic thyroid process.

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Munchausen syndrome: case reports and literature overview

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ABSTRACT: *Munchausen syndrome is a subset of factitious disorders with a number of distinguishing characteristics. This article presents three case reports and brief discussions to facilitate recognition. Management techniques are also presented.*

Almost all practicing physicians will encounter a patient who fabricates an illness. Factitious illnesses must be differentiated from malingering (feigning an illness for a specific benefit) and somatoform disorders. Patients with somatoform disorders or hypochondriasis present with symptoms that are not under voluntary control. By contrast, factitious disorders are characterized by feigning symptoms of disease or willfully producing symptoms such that repeated and complex medical evaluations are required. The act of producing the symptoms or the diagnostic testing may put the patient at significant risk. Such patients may be very difficult to diagnose, evaluate, and treat. Munchausen syndrome, a specific subset of factitious disorders, is the most dramatic presentation (see **Table 1**).

Case history 1

MH, a 33-year-old white man, presented to the emergency room at 10:30 p.m., complaining of severe abdominal pain. He gave a history of having had an appendectomy as a teenager and subsequent surgery some years later to relieve a small bowel obstruction.

Physical examination showed the patient to be afebrile. He appeared to be adequately hydrated. The abdomen was firm with moderate to severe tenderness that was not well localized. Bowel sounds were present. There appeared to be no evidence of peritoneal irritation.

The white blood cell count was within normal limits. X-rays of the abdomen showed some small bowel gas and some gas in the rectum. There

* *Material mentioned in this article has not been approved by the U.S. Department of Defense or by the Uniformed Services University of the Health Sciences.*

Table 1. Characteristics reported in Munchausen syndrome

- evasive manner
- denial of previous surgeries/medical history
- acute presentation
- dramatic symptoms
- medical sophistication (unusual grasp of terminology, procedures, etc.)
- remarkable life stories of heroism, war exploits, professional achievement
- demands for medication (typically, analgesics or narcotics)
- peregrination (travel from city to city, hospital to hospital)
- consuming desire for medical care
- lack of visitors
- medical history not entirely convincing
- shifting complaints
- previous caregivers difficult or impossible to contact
- arrival in emergency department late at night or at change of shift
- lack of steady employment
- predisposing physical illness
- personality disorder(s) with absence of major psychiatric illness

were no frank air fluid levels. The initial impression was that there could be partial, early small bowel obstruction.

The patient was taken to the operating room that evening because of continuing severe abdominal pain, but no definite bowel obstruction was found. There were extensive adhesions and evidence of a previous bowel resection.

Following surgery, the patient continued to complain of severe abdominal pain and required large doses of narcotic. By postoperative day 10, he was still complaining of abdominal pain, as well as nausea and vomiting.

A gastrointestinal (GI) consultant noted that the abdominal film showed the presence of vagotomy clips, indicating surgery to which the patient had not admitted. Further investigation was undertaken, which included upper GI with small bowel series, gastric emptying study, and upper endoscopy. No obstruction or delayed gastric emptying was noted. The patient's "vomitus" appeared more like saliva. At one point, he collapsed in the hall due to severe abdominal pain.

Careful questioning of the patient and subsequent investigations of his statements revealed that he had not told the truth about a number of things. His mother, with whom it was discovered he lived, said he would disappear for several weeks at a time. When asked, the surgeon reported that the patient had very dense adhesions in the midline. The patient changed the location of the hospital where he originally claimed to have had the appendectomy; the second hospital reported that the patient had had several recent surgeries there for presentations similar to the current hospitalization. It was ultimately determined that the patient had been hospitalized more than 10 times in the previous two years and had multiple surgeries with multiple diagnoses, including ulcerative colitis; erosive gastritis; hernia and Crohn's disease, and repair of an incisional hernia; and excision of scars, lysis of adhesions, and multiple surgeries for small bowel obstruction.

When the patient was advised of these findings, he promptly asked to have his intravenous line removed and, despite the fact that a very short time before he had been again complaining of severe pain, he got dressed and left the hospital against medical advice.

The case of MH illustrates several facets of Munchausen syndrome that may aid in diagnosis:

- *Evasive manner;* MH told several untruths and changed his story several times about previous surgery and where he lived.
- *Denial of surgery.*
- *Acute presentation;* MH went to the emergency room of a hospital where he had never been a patient at a time of day when it is difficult to obtain previous records.
- *Medical sophistication;* MH produced symptoms sufficiently convincing to lead to surgical intervention.[4] Patients with Munchausen's syndrome can often recount textbook descriptions of the onset and causes of the alleged illness.

Case history 2

PA, a 41-year-old white man, had undergone dental surgery a week prior to admission to the emergency room for complaints of chest pain, which he felt was related to an allergic reaction to the antibiotics prescribed by the oral surgeon. While undergoing a stress test, he had sudden onset of severe and progressively excruciating pain in the lower quadrant that radiated to his left groin and left testicle. There was no history of urolithiasis. The patient claimed to be a retired Navy Seal who had sustained extensive war wounds and displayed extraordinary heroism behind enemy lines in three major, recent conflicts. He claimed that, as a result of his injuries, he had plastic surgery to his abdomen and a number of "rearrangements" of his bowel. A urologic consultant found no specific urologic abnormality.

During a GI consultation, the patient writhed in severe pain despite being on a continuous infusion of meperidine hydrochloride (Demerol). His abdomen was distended and there were multiple scars across the body on the abdomen and extremities. The patient denied any surgery since being in the

Navy. His abdominal films appeared unremarkable and he had good bowel sounds.

Telephone inquiries to other area hospitals disclosed multiple hospitalizations. The patient's wife said he had been a heavy alcohol abuser and that he had been hospitalized recently for complaints similar to the current admission. A psychiatric consultation was requested. Throughout the patient's hospitalization, data from laboratory studies showed no specific abnormalities. The patient promptly signed himself out of the hospital against medical advice.

The foregoing case illustrates *pseudologica fantastica*,[5] which is habitual, uncontrollable, pathologic lying characterized by fantastic details (e.g., being a military commander, an undersea diver, a fighter pilot, a former member of underground resistance, a criminal lawyer, a physician).[6] The patient in this case displayed a tattoo of a dolphin, which he claimed was the emblem of his Seal unit. He stated that no one could corroborate the details of his military exploits because all the members of his squad were killed. He also stated that at one time he had thrown himself on a grenade to save his comrades! Despite an extensive search, no records of his alleged military service could be found.

Factors illustrated in the case of PA that may aid in the diagnosis of Munchausen syndrome include:

- *Visible evidence of previous surgeries* (multiple abdominal scars).
- *Demands for medication,* typically narcotics. No dose of meperidine was adequate to relieve PA's pain.[4]
- *Peregrination*[7] (traveling from city to city). Careful review of PA's history revealed traveling from city to city and hospital to hospital.
- *Being consumed with attempts at hospitalization and receipt of medical care.*
- *Lack of intimate involvement with others is associated with the patient's need to conceal the fictitious nature of the alleged illness.*[7] PA had no visitors during his hospitalization.

Case history 3

JR, a 27-year-old woman from out of town, presented late in the evening to the emergency room at a community hospital. She gave a complicated medical history that included a seizure disorder, as well as esophageal problems, laryngospasm, and asthma, which she called "ROADs" (reactive obstructive airway disease). The patient had an indwelling catheter in the right subclavian vein. Complaining that she was choking and having difficulty breathing, she demanded endoscopy, for which she required up to 300 mg diazepam (Valium). She relayed these messages by writing on the bed sheets.

The patient developed marked respiratory distress with stridor. A pulmonary consultant noted that she was breath-

The term Munchausen *syndrome was first coined by Asher.[1] The good Baron Friedrich Hieronymus von Munchausen served in the Russian army in the war against the Turks. The baron became well known for his preposterous tales of his exploits, one of which is quoted below.*

> I went on [a journey to Russia]. Night and darkness overtook me. No village was seen. The country was covered with snow, and I was unacquainted with the road.
>
> Tired, I alighted, and fastened my horse to something like a pointed stump of a tree which appeared above the snow, where I slept soundly and I did not open my eyes till full daylight. It is not easy to conceive my astonishment to find myself in the midst of a village lying in a church yard; nor was my horse to be seen, but I heard him soon after neigh somewhere above me. On looking upwards, I beheld him hanging by his bridle to the weathercock of the steeple. Matters were now plain to me; the village had been covered with snow over night; a sudden change of weather had taken place. I had sunk down to the churchyard whilst asleep, gently, and in the same proportion as the snow had melted away, and what in the dark I had taken to be a stump of a little tree appearing above the snow, to which I had tied my horse, proved to have been the cross on the weathercock of the steeple! Without long consideration I took one of my pistols, shot the bridle in two, brought down the horse, and proceeded on my journey.[2]

Even more fantastical, the baron produced an affidavit signed and notarized by Gulliver, Sinbad, and Alladin to "attest to his veracity."[3]



Karl Friedrich Hieronymus von Munchausen (1720-97)

ing against a closed glottis, and examination indicated a history of previous intubations. The patient's primary physician could not be contacted by telephone.

The patient subsequently had several classic tonic clonic (grand mal) seizures. Her postictal course was unusual. Large doses of diazepam were required to prevent recurrences. Most of the seizure activity occurred on the left side; the patient appeared to be protecting the Hickman catheter with her right arm. She gave a history of allergies to certain antiepileptic drugs except phenytoin (Dilantin). A neurologic consultant was called. The patient was given phenytoin and advised to stay within the hospital. The family (including the husband, who remained somewhat belligerent and angry throughout the emergency room visit) refused to allow the patient to be admitted to the hospital.

The following day, a discussion with the primary physician revealed that the patient had been carefully observed at a major medical center with workup for her seizures. She was given a diagnosis of pseudoseizures and Munchausen syndrome. She had had numerous intubations for breathing against a closed glottis. In addition, she had been admitted for severe, unexplained anemia, which her physician believed was due to the patient's bleeding herself through the Hickman catheter. The catheter was present because no additional sites were available to start an IV line.

Factors illustrated in this case that may aid in the diagnosis of Munchausen syndrome include:

- *Excellent grasp of medical terminology.*
- *Medical history and urgent problem that are not entirely convincing.* Venous cutdown sites were visible at several locations upon careful examination.
- *Shifting complaints.* JR first complained of difficulty swallowing due to esophageal obstructions and later developed uncontrollable seizures.
- *Use of the emergency department.* With their heavy case load and little or no prior knowledge of patients, who typically cannot reach their primary care physician, hospital emergency rooms are the ideal port of entry for those with Munchausen syndrome.

JR was accompanied by a demanding, threatening husband who intimidated and bullied the physicians in the emergency department and claimed that he would sue them. When one physician recognized the patient from another hospital, the patient's seizures suddenly remitted and she and her husband left, stating that the hospital "had been ruined for them." Thus, JR's case also demonstrates some features of *Munchausen's by proxy*, wherein a caregiver, usually a mother, plays a variety of roles in illness simulation.[10] The case of JR is unusual in that most reported patients are men.

Psychological factors

Munchausen syndrome is incompatible with the person's maintaining steady employment and family ties.[11] There is often a true predisposing physical disorder during childhood or adolescence. Associated features may be significant signs of a personality disorder, such as dependence, exploitativeness, or self-defeating behavior. Acute object loss (e.g., loss of a family member) may be a precipitating event.[10]

Management

The most trying time for physicians and staff is the period prior to diagnosis. Meetings of the ward staff, nurses, physician(s), and liaison psychiatrist must be arranged. The patient should be recognized as being sick. The psychiatrist should be present during the initial discussions and should remain after the physician has left the room to discuss the situation.[12]

Patients may believe they have an underlying disease and simulate it so as to continue the medical workup. Patients see their physicians as their allies and do not obtain emotional satisfaction from fooling or tricking the medical staff. It is often apparent that many patients have some medical training (e.g., nurse, medical technician).

Patients consider themselves and their illnesses to be important. They will resist psychiatric intervention angrily, or with covert passivity and negativity. Suffering should be acknowledged, but patients should not be encouraged in their fixed beliefs about their illnesses. Any sign of healthy adaptation should be encouraged. In addition, attempts should be made to see the patient in an outpatient setting on a regular, nonsymptom-linked schedule. Family members should be involved and attempts should be made to identify as many supportive avenues as possible.[13]

As Hippocrates stated, "It is more important to know what kind of person has the disease than what kind of disease the person has."[14] Awareness of the diagnostic criteria for Munchausen syndrome and the many modes of presentation will help caring physicians formulate the diagnosis. Treatment is rarely successful,[10] but attempts to initiate therapy should always be made.[15]

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Homesickness responsive to antibiotic therapy?

In a recent letter to the editor of the *American Journal of Psychiatry*, the authors note that nostalgia (i.e., homesickness) was considered a serious mental illness as early as 1688 and that it retains its medical respectability as an ICD-9 diagnosis, adjustment disorder.[1] It was therefore interesting to read in the same issue of the journal a case report of a college student diagnosed as having an adjustment reaction to being away from home following the sudden onset of severe, sustained anxiety, depersonalization and panic attacks associated with insomnia and appetite loss. Sent home two weeks later, she was given an extensive medical workup. The only abnormalities were two tests that were positive for Lyme disease. The patient's psychiatric symptoms responded rapidly to intravenous antibiotic treatment.[2]

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A report presented at the Annual Meeting of the American Society of Nephrology (October 1994) indicates there may be a strong correlation between even small increases in blood pressure and eventual kidney failure. Results of a study of over 361,000 men followed for a mean of 15.3 years showed that 924 developed end-stage renal disease. Men whose diastolic blood pressure was 120 mmHg or higher were 30 times more likely to develop ESRD than subjects whose DBP was lower than 70 mmHg. Systolic blood pressure of 200 mmHg or higher also was associated with significantly increased risk of developing ESRD. The findings for increased risk were independent of age, race, number of cigarettes smoked, previous heart attacks, diabetes, income, and serum cholesterol. Michael J. Klag, M.D., M.P.H., associate professor of medicine at The Johns Hopkins Medical Institutions, was the lead author of the study.

Pertinent medical intelligence: methadone ingestion in children

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Methadone maintenance treatment is widely used throughout the United States for chronic opiate dependence.[1] In Maryland, 12 publicly funded treatment centers dispense methadone to approximately 3600 patients per year (Maryland State Alcohol and Drug Abuse Administration, unpublished data, 1992). In addition, there are seven fully licensed, privately funded treatment centers that enroll approximately 800 to 1000 patients per year. In 1992, a total of 1,679,000 doses of methadone were dispensed in the state of Maryland. Although the benefits and hazards of methadone as therapy for opiate addiction have been widely studied and debated, very little attention has been given to children who suffer morbidity and mortality as a result of accidental ingestion of this substance. We report two such cases in our institution over a three-month period.

Case 1

A 4-year-old boy presented to the emergency room (ER) in asystole. The child's mother and grandmother reported that he had been well until that morning, when he was noted to be lethargic and breathing irregularly, but afebrile. The patient went to sleep and when the mother tried to arouse him several hours later, he was unresponsive, with blood coming from his nose and mouth. In the ER, he was apneic, pulseless, and had fixed and dilated pupils. Dried blood was noted in both nostrils and the mouth. With direct laryngoscopy, a scant amount of fresh blood was suctioned from the hypopharynx. There was no external evidence of trauma and no blood upon evacuation of the stomach contents. The patient was unresponsive to resuscitative efforts.

The next day, an anonymous caller said that the patient's grandmother worked as a nurse in a methadone treatment center and was stealing the drug to sell it. Further investigation indicated that the night before the patient died, a bottle containing 40 mg of methadone had been left on the dining table and that the child apparently had ingested the drug. Soon after, the patient became

combative and agitated, but no medical intervention was sought at that time. Postmortem examination showed the cause of death was methadone poisoning; the blood methadone level was 0.5 mg/L.

Case 2

An 8-month-old boy was transferred to our facility from another hospital because of seizure activity. The patient was well until two days prior to admission, when he developed coryza, vomiting, and fever. According to the history, the mother had left the baby with his father; when she returned, she noticed that the baby was unresponsive with twitching of the left leg. The twitching soon generalized. In the ER, the baby was noted to be cyanotic and poorly perfused. He was endotracheally intubated and given volume resuscitation. The patient's condition stabilized, and he was extubated after 12 hours. On the second hospital day, the patient was fully awake and asymptomatic. Serum electrolytes were normal; cultures of blood, cerebrospinal fluid, and urine were negative; an electroencephalogram and magnetic resonance imaging study of the head were normal. Urine toxicology screen (by immunoassay) was positive for methadone. The serum toxicology screen was negative. Upon further inquiry, it was disclosed that the baby's father was enrolled in a methadone treatment program.

Discussion

Pharmacologic effects. Methadone hydrochloride is a synthetic μ-agonist with pharmacologic properties similar to those of morphine.[2] It is used in the management of opiate addiction because its long duration of action suppresses withdrawal symptoms in individuals physically dependent on those substances. It is well absorbed from the gastrointestinal tract and can be detected in plasma within 30 minutes after oral ingestion.[3] Peak plasma concentration is reached at 4 hours. Analgesia lasts from 4 to 6 hours and physiological effects last 24 to 48 hours.[4] The half-life of methadone is 1 to 1.5 days.[5] It is highly protein bound in various tissues, including brain.[3] Clinical effects include miosis, bowel and bladder retention, and peripheral vasodilatation that may cause orthostatic hypotension.[6] Pulmonary edema has been reported in methadone poisoning in adults and children.[7,8] Neurologic symptoms range from lethargy to coma.[2,9] Respiratory depression is the most serious toxic effect of methadone. There is a decrease in minute ventilation, depression of cough, and bronchial smooth muscle contraction. With large doses, there is a more severe decrease in alveolar ventilation leading to carbon dioxide retention and eventually causing an increase in cerebral blood flow and increased intracranial pressure.[2,6]

The toxic dose of methadone in children has not been established.[2,6,10] As little as 10 mg has been reported to be lethal in a child,[8] and 5 mg has been reported to cause apnea and coma.[2] By contrast, adults, particularly opiate addicts, may tolerate up to 100 mg with few symptoms.[11] The suggested analgesic dose for methadone is 0.7 mg/kg/day divided into four or six doses.[2] Our first patient ingested approximately 2.5 mg/kg. The toxic range of methadone in children or adults is 0.4 to 1.8 mg/L.

Dispensing regulations. Patients are enrolled in methadone maintenance centers voluntarily and must fulfill eligibility criteria as defined by section 4 of the Comprehensive Drug Abuse Prevention and Control Act of 1970.[12] The initial dose of methadone is 20 to 30 mg/day, dispensed by a licensed health care professional supervised by and under the order of a physician. The dose is gradually increased as needed to suppress withdrawal symptoms, with a maximal dose of 120 mg/day. Most programs dispense 40 to 60 mg per patient per day.

The liquid form of methadone is mixed with fruit juice and dispensed in paper cups; it is to be taken in full view of a staff member or, if the patient is permitted take-home drug therapy, the liquid is placed in individual, single-dose plastic bottles with childproof caps. Each bottle must be clearly and properly labeled with the word *methadone* and the name, address, and telephone number of the treatment center. Some centers also print a warning statement on the label, although this is not required by the U.S. Food and Drug Administration (FDA).

Several factors (outlined in the Code) influence which patients are allowed to visit the methadone maintenance center less frequently and receive take-home doses. These include the patient's duration and regularity of clinic attendance; absence of use of drugs other than methadone, including alcohol, as evidenced by negative urine and serum toxicologic screens; absence of recent criminal activity; and competence to store the methadone safely (deemed by the medical director). Under no circumstances is a patient given more than a two-week supply of methadone. All patients are randomly checked for opiates in their urine. If they test negative for methadone or positive for another drug, they are put on a three-month probation. During the probation period, their take-home supply is reduced and the number of clinic visits is increased.

Accidental ingestion. Although the methadone treatment program is tightly controlled by the FDA and the U.S. Drug Enforcement Agency, methadone ingestion in children has become an increasing problem. As more patients have enrolled in methadone maintenance programs, there has been a parallel rise in the reported number of accidental methadone ingestions. In 1992, 40 to 50 million methadone doses were distributed throughout the United States. During the same period, the

American Association of Poison Control Centers reported 36 methadone ingestions in children younger than 6 years of age nationwide,[13] a six-fold rise in *reported* cases over any previous year.

Mixing liquid methadone with cherry- or orange-flavored fruit juice makes it attractive and palatable to children.[14] Many opiate addicts may underestimate the serious toxicity of methadone in children. Because they may perceive adult dosage (e.g., 40 mg) as harmless, caregivers may ignore ingestion by a child and fail to seek prompt medical treatment. If the methadone was obtained illegally, parents or caregivers may be afraid to report ingestions. Those who do obtain their methadone legitimately may fear expulsion from their programs or loss of their acquired privileges if their competency in child care is questioned. Such factors may be more pertinent for accidental methadone ingestions than for ingestion of other substances because methadone is widely dispensed and available to people who are considered "high risk" for child abuse and neglect.

Re-thinking the regulations. There seems to be a need to reexamine the criteria used in allowing medication to be taken home and to reassess measures to prevent pilferage of the methadone. There should be close surveillance of take-home doses dispensed, such as home visits to ensure proper medication storage in homes that have children. In addition, the criteria used to judge eligibility for take-home doses should be modified to make it more difficult for patients with children to take the methadone home. Treatment center staff must be screened closely, and access to methadone should be allowed only to a few employees, who should be monitored when pouring doses. Finally, methadone should be dispensed in a form that is less palatable to children.[15]

Conclusion

By virtue of its availability in treatment programs, methadone has been increasingly implicated in childhood ingestions. Many of these ingestions result in significant morbidity and mortality, even in doses that may be considered nontoxic to adults. The two cases in our institution that occurred within a three-month period may represent an alarming increase in incidence. Closer surveillance by state and local authorities is warranted because accidental methadone ingestion represents a preventable morbidity in a high-risk, low-report population. Methadone should be considered, and a toxicologic evaluation performed, in any patient, adult or child, who presents with unexplained coma or apnea, particularly if there is a family history of drug abuse.

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Although asthma is more likely to be diagnosed by the age of 10, approximately 15% of all cases are diagnosed after age 40. Asthma should thus be part of the differential diagnosis of any adult with new episodic shortness of breath.

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Vignette of medical history: the Trimbles of Baltimore

Joseph M. Miller, M.D.

Dr. Miller is a retired surgeon in Timonium, Maryland.

The Medical and Chirurgical Faculty of Maryland has been fortunate to have among its members a number of illustrious families. During the last century, the Trimble family has been one of its more prominent.

Major General Isaac R. Trimble (1802-1888)

The Trimble name was entered into local history not by a medical man, but by a soldier and engineer through a not unusual set of circumstances extant at the beginning of the Civil War.[1-7] Both the Union and the Confederacy had ardent sympathizers in Maryland and friction between them was frequent. On April 14, 1861, Fort Sumpter surrendered and subsequent events in Baltimore led to several ugly situations. Four days later, city officials received word that two companies of Union army troops would pass through Baltimore that day on their way to Washington. As the soldiers marched from the terminal of the Northern Central Railroad to entrain at Mount Clare Station, they were met by a mob of Baltimoreans intent on harassment. The local police prevented a confrontation and riot by a narrow margin.

A similar situation occurred the next day, but the outcome was not as good. The transfer of the Sixth Massachusetts Regiment between terminals offered an opportunity to stone one car. Track obstruction necessitated that the soldiers walk and gunfire followed; however, order was again restored by the police. New York troops arriving at the President Street Station were forced to return northward. A personal appeal was then made to President Lincoln to have troops passing to Washington detour around Baltimore. To prevent any further transit, the railroad bridges north of the city were burned.

On Sunday, April 21, Baltimore was aroused by church bells when intelligence indicated that 5,000 Union troops were at Cockeysville preparing to march on the city. The citizenry was alerted and within five hours, armed forces under the command of Colonel Isaac R. Trimble were prepared to defend the area from invasion. Upon order of President Lincoln, the troops returned to Harrisburg without a confrontation, and the local militia was disbanded.



Major General Isaac R. Trimble, Confederate States of America *(courtesy of the Maryland Historical Society).*

Colonel Trimble was commissioned a second lieutenant in the artillery upon his graduation from West Point in 1822. He resigned from the Army in 1832 to pursue a career as a civil engineer with various railroads operating out of Baltimore. At the onset of the hostilities between North and South, he was general superintendent of the Philadelphia and Baltimore Central Railroad.

Going to Virginia later in 1861, he received a commission as a colonel in the state troops and on August 9 he was made a brigadier general in the Confederate service. After supervising construction of batteries along the Potomac River, he was assigned a brigade in the Army of Northern Virginia. He saw action at Manassas Junction and then became a part of Ewell's division in the operations in the Shenandoah Valley. He gave conspicuous service in battles at Winchester, Cross Keys, and around Richmond. In 1862, he saw action at Cedar Mountain, Hazel Run, and Bristoe Station. At Manassas, he was wounded seriously and subsequently was made a major general. He recovered to take part at Gettysburg, but again he was wounded and amputation of the left leg was necessary. He is epitomized in some records as having led, with four other general officers, the charge at Gettysburg for which Pickett is usually given credit. At that time, he was taken prisoner and did not see further action. He returned to Baltimore after the hostilities ended in 1865, and made his home there until his death.

Isaac R. Trimble, M.D. (1861-1908)

The son of David Churchman Trimble (who was not a physician) and the grandson of Major General Trimble, Isaac R. Trimble, M.D., was a Baltimore surgeon of high standing. Educated at the Shenandoah Valley Academy and Johns Hopkins University, he received his medical degree at the University of Maryland in 1890, served his residency at the hospital, and started his practice in Baltimore. Having a strong interest in military matters, he became assistant surgeon to the Fifth Regiment of the Maryland National Guard and remained in the Guard for the rest of his life. At the time of his death, he was chief surgeon to the First Brigade.

During the administration of Governor John Walter, Dr. Trimble served as his surgeon general.[8] Dr. Trimble was professor of anatomy and clinical surgery at the Women's Medical College from 1893 to 1899 and dean of the school from 1894 to 1896.[9] He also served as a lecturer on clinical surgery at the University of Maryland from 1894 to 1899.

In the midst of a highly successful surgical career, Dr. Trimble suffered an injury to his left hand while operating on a patient with a severe infection. A septicemia followed, causing his death.[10,11]

I. Ridgeway Trimble, M.D. (1900-1979)

Dr. Trimble's son pursued the traditional educational course of many young Baltimoreans. He was educated at the Calvert and Gilman schools and then went to Princeton for his collegiate work. He obtained his medical school training at Johns



Isaac R. Trimble, M.D. *(courtesy of the Medical and Chirurgical Faculty of Maryland).*

Hopkins, where he then served a surgical residency for seven years. Except for a hiatus caused by World War II, he practiced general and vascular surgery in Baltimore until his retirement in 1978.

Like his father and great-grandfather, Dr. Trimble had considerable interest in military affairs.[12-14] Commissioned a major in the Army Medical Corps in 1940, he subsequently was chief of surgery of one of the two units sent from the Hopkins Hospital. He then became chief surgical consultant for the Army forces in the Pacific Theater, serving on the staff of General Douglas A. MacArthur. He was awarded numerous citations for his work in the Army, from which he retired in 1946 as a colonel.[10,11]

During his military career, one of Dr. Trimble's interests was improving and distributing a bullet-proof vest for the infantry.[17] Because of his initial efforts, the vests saw early limited use in the Pacific theater and then were prepared in quantity to outfit the military force being assembled to storm Japan. Dr. Trimble maintained his interest in this life-protecting device, which later was used in Korea and then in police departments in many areas of this country.

Dr. Trimble was a competent surgeon and one of his best known contributions was the creation of a one-stage operation for carcinoma of the head of the pancreas and the ampulla of Vater.[15] He was also interested in the treatment of peripheral vascular disease with sympathectomy.[16] He was on the staff of many local hospitals and a member of numerous national surgical societies.

In 1913, the Trimble lecture, a feature of the Med Chi Annual Meeting, was established in recognition of the high standard of medical and surgical practice to which the elder Dr. Trimble was devoted. A natural reaction after the death of his son was the creation of a combined lectureship to acknowledge his many parallel contributions.[18]



I. Ridgeway Trimble, M.D.
(courtesy of Frances H. Trimble, M.D.).

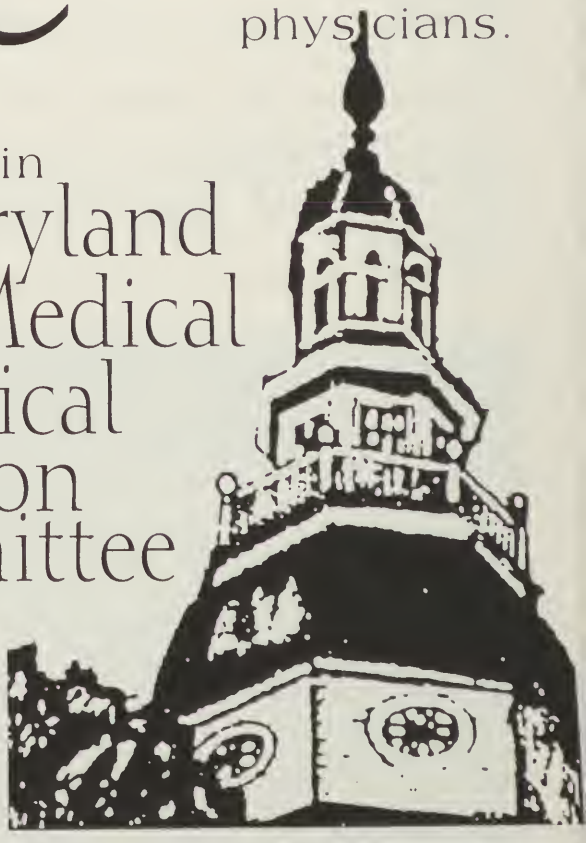
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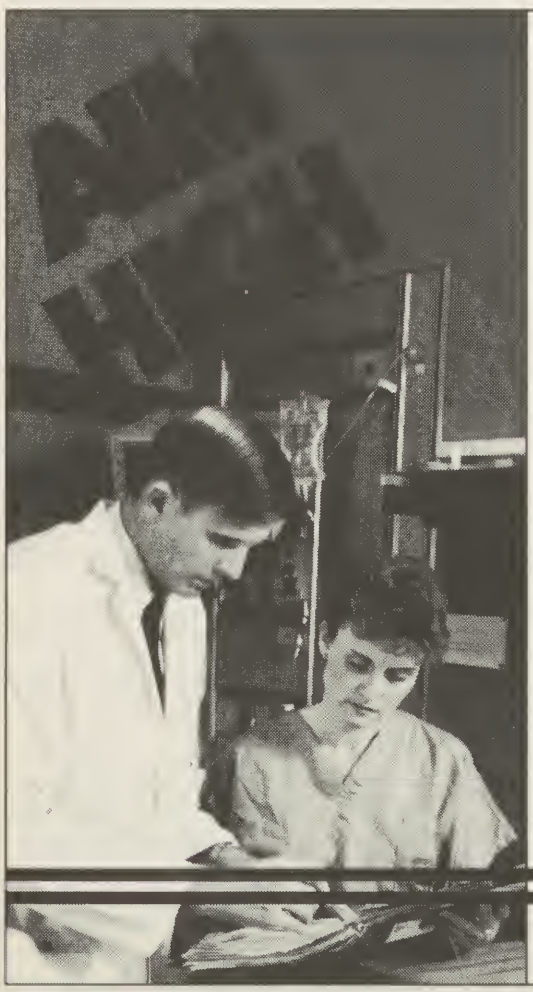
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Geriatrics for the Clinician

ASSESSMENT OF CAREGIVER STRESS

Most people would prefer to be the caregiver to an elderly family member with physical or cognitive impairments, rather than place their relative in a nursing home. Over the past decade, however, an increasing number of studies have documented that caregivers to elderly relatives experience high levels of stress, depression and anxiety, physical and psychological health problems, increased use of psychotropic medications, and financial burden. Recent articles have called on primary care physicians to become more aware of the stresses of caregiving and to play a larger role in detecting and managing stress in caregivers. In 1993, the American Medical Association Council on Scientific Affairs advocated a "model for partnership" between physicians and caregivers.[1] According to the model, the physician conducts periodic assessments of both the elderly patient and caregiver, validates the role of the caregiver, and acts as a case manager. This article presents a brief description of caregivers and possible sources of stress, efficient methods for primary care physicians to identify stress in caregivers, and resources to help caregivers manage or reduce stress.

Definition

A caregiver is one who provides unpaid supervision or assistance with basic activities of daily living to persons whose physical or mental health prevents them from living independently. According to the 1982 National Long-Term Care Survey (NLTCS), there were 2.2 million caregivers to 1.6 million noninstitutionalized frail elderly adults in the United States.[2] Most of these caregivers were women (72%) and were the care recipient's spouse (36%) or adult daughter (29%). Almost all helped with shopping and transportation (86%), and a majority helped the care recipient with feeding, bathing, dressing, and toileting (67%). One fifth of the respondents had been performing caregiving activities for their relative for more than five years. These caregivers helped to prevent nursing home placement and hospitalization and to optimize the quality of life of their relative.

Sources of stress

Caregiving may be stressful for various reasons. Stress may result from physical demands of caregiving, such as lifting, being unable to leave the care recipient unsupervised, or being awakened during the night. The clinical features and functional limitations associated with different conditions may be stressful to caregivers: these range from behavioral and cognitive impairments associated with Alzheimer's disease and other dementias to physical limitations in persons with hip fracture or stroke.[3] In our research, caregivers have reported that it is emotionally difficult to help a relative with activities such as bathing, eating, and toileting (unpublished data). In addition, caregivers may be stressed by the unpredictability of the course of their relative's condition or caregiving needs, uncertainty of how to prepare for those needs, and increasing needs of their relative over time.[4]

Stress also may result from the caregiver's multiple responsibilities and consequent lack of time for non-caregiving activities. One fifth of the NLTCS caregivers reported conflicts between work and caregiving.[2] Caregivers may face financial burdens due to the costs of home health care or quitting a job in order to care for a relative. Efforts to obtain and coordinate home care and social services may be frustrating.[5] Moreover, psychological aspects of being a caregiver to an aging parent may be stressful: these include the past relationship between the caregiver and parent, the reversal of parent-child roles, and recognition of the caregiver's own aging.[5]

Detecting and reducing caregiver stress

Because of their long-term relationships with the patient and family, attention to psychosocial well-

being, and role as coordinator of health services, primary care physicians are well suited to identify stress and suggest interventions.[1]

Physicians might identify caregivers in two ways: when relatives bring an elderly patient for a medical appointment, and by asking all patients aged 45 and older if they have caregiving responsibilities.[4] The presence of stress may be assessed by asking about physical symptoms (e.g., back pain, tension, fatigue) and emotional symptoms (e.g., feeling depressed, anxious, irritable, resentful, or guilty about the relative).[4] Physicians also may inquire about stress-related behaviors such as weight change, increased use of alcohol or cigarettes, use of psychotropic medications, changes in sleep patterns, decreased time spent in social activities. In our research, caregivers were more likely to report these behaviors than to score in the "stressed" range on multi-item scales (unpublished data). Physicians may ask about factors that buffer the caregiver from stress, such as the presence of a confidant and whether the caregiver has time away from caregiving activities. They may provide emotional support by asking about the tasks the caregiver performs and the caregiver's need for assistance, and acknowledging the caregiver's positive and negative feelings toward caregiving.

Caregivers may hesitate to relinquish aspects of caregiving to a formal care provider, but they may be willing to follow a physician's recommendations. Services may assist the caregiver with actual caregiving tasks (e.g., home care, nursing care, respite services) and psychological stresses of caregiving (e.g., support groups; counseling by a social worker, psychotherapist, or clergy).

Physicians may provide information on the expected course of the care recipient's condition, or about community resources (e.g., adult day centers, respite services, the Alzheimer's Association, support groups). If caregivers are employed, they should inquire about Eldercare policies at the workplace. Much of this information can be obtained from county offices on aging and associations such as the Alzheimer's Association.

Current trends suggest that more adults will become caregivers to their elderly parents, spouses, or other relatives. These trends include the growth of the elderly population, policies to discharge hospitalized patients, and rising costs of long-term care. Primary care physicians may assist caregivers and elderly patients alike by providing information to caregivers, being able to detect stress, and recommending resources to alleviate stress, if necessary.

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Imaging Case of the Month

Demonstration of Malignant Pleural Effusion by Bone Scan

A 54 year-old woman with adenocarcinoma of the right lung was referred to the division of nuclear medicine for a whole-body bone scan to rule out osseous metastases.

Imaging findings

A whole-body bone scan (**Figure 1**) was performed in this patient with a known lung tumor and large pleural effusion to exclude bony metastatic disease. There were no abnormal areas of tracer activity to osseous structures. There was diffuse increased activity in the region of the right hemithorax on the whole-body images, which were taken with the patient in the supine position. An additional spot view of the chest (**Figure 2**) taken with the patient erect showed the activity moving dependently to the inferior portion of the right hemithorax consistent with pleural effusion. Plain radiographs of the chest (**Figures 3a** and **3b**) showed a large, free-flowing right pleural effusion that did not displace mediastinal structures to the contralateral side as may be expected. This is suggestive of underlying volume loss involving the right lung. The plain film finding was confirmed by computed tomography (CT) scan of the chest (**Figure 4**). There was a right middle lobe mass lesion with ill-defined boundaries and apparent cut-off of the right middle lobe bronchus. These features are strongly suggestive of a carcinoma with associated post-obstructive change. There was also involvement of the right main stem bronchus. There was a second spiculated nodule in the right upper lobe as well as extensive mediastinal lymphadenopathy. By radiologic staging, this would be at least a stage IIIa tumor. The pathologic diagnosis was pleural fluid cytology consistent with adenocarcinoma.



Figure 1. Whole-body images from a radionuclide bone scan taken with the patient supine demonstrate diffuse increased activity involving the right hemithorax. This is best seen on the posterior view (arrow).

Discussion

Diffusely increased hemithoracic activity in radionuclide bone scans secondary to pleural effusions with both benign and malignant cytology is well described.[1-4] This finding appears to be nonspecific and has been seen in patients with bone neoplasm, various nonbony solid tumors, and hematologic malignancies. The phenomenon also has been demonstrated in patients with effusion secondary to simple infection.[5]

Sandler et al[1] have defined the following specific scintigraphic criteria for the diagnosis of pleural effusions on bone scan:

1. Posterior view: hemithoracic asymmetry, decreased costal/intercostal contrast.
2. Anterior view: "triangle sign," asymmetrically increased activity in a triangle formed by the lateral sternal border, the costochondral junctions, and the level of the diaphragm.
3. Anterior and posterior view: a steep activity gradient at the level of the diaphragm.

Excessive vascular permeability is the most widely accepted mechanism for increased activity in pleural effusions.[6] The increased activity occurs within the pleural fluid itself and not within malignant cells. It is due to technetium-99m-methelene diphosphonate and not to free technetium-O4 or a metabolite.

By retrospectively reviewing results in 74 patients who underwent both bone scanning and pleural fluid cytology within a

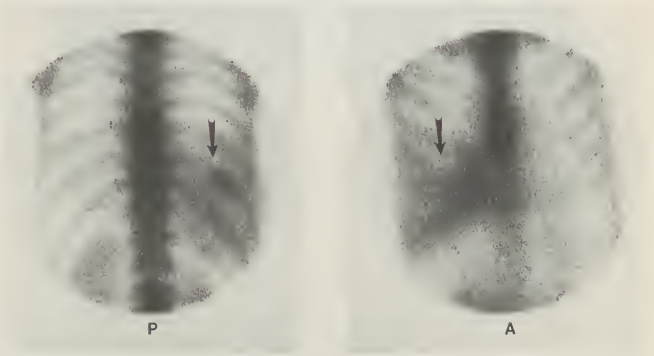
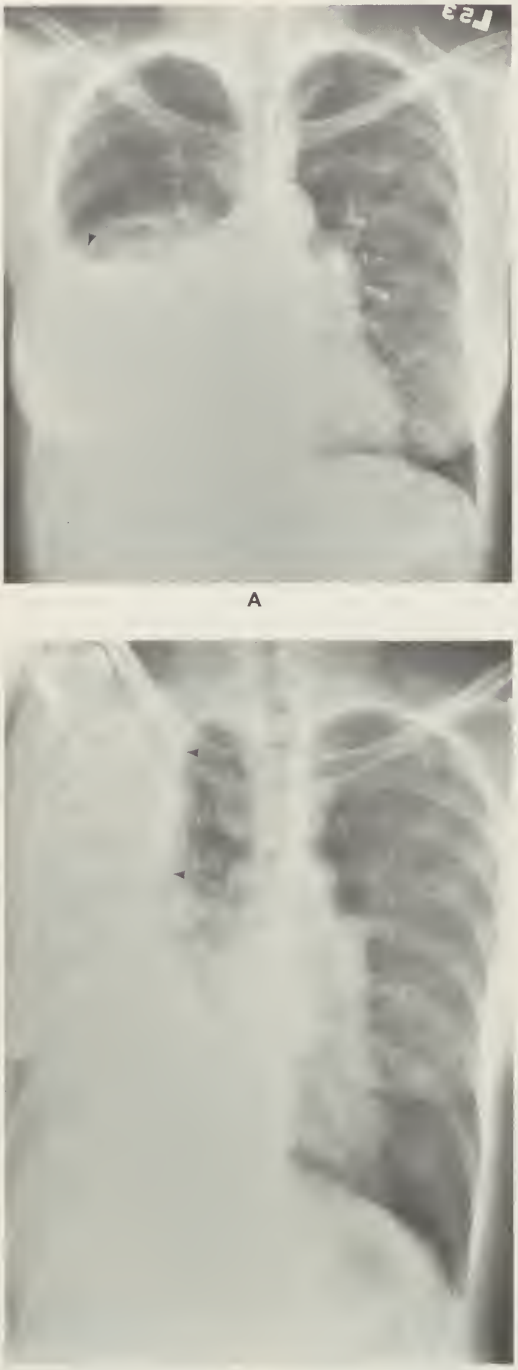


Figure 2. Additional anterior (a) and posterior (b) images with the patient in the upright position demonstrate shift of activity to the inferior portions of the right hemithorax consistent with tracer accumulation in a free-flowing pleural effusion (arrow indicates top of activity).



A

B

Figure 3. Plain PA (a) and right-side down decubitus (b) chest radiographs demonstrate a large, free-flowing pleural effusion (arrowheads) filling approximately half the right hemithorax.



Figure 4. Selected images from a CT scan of the chest demonstrate a mass lesion (large arrowhead) on the right middle lobe that has poorly defined boundaries. There is involvement of the right middle lobe bronchus and bronchus intermedius. The pleural effusion is also demonstrated (small arrowheads).

defined interval between both tests, Sandler et al[1] estimated a sensitivity of about 40% and a specificity of about 80% for the detection of malignancy on bone scan. Considering the above findings, bone scanning would not be a useful screening test for the detection of malignant effusions. They conclude, however, that given the limitations of cytologic diagnosis (e.g., inadequate sampling, degraded material), when pleural effusion is detected on bone scans, the diagnosis should be pursued beyond pleural fluid cytology if it is negative or indeterminate.

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MICHAEL F. DOWE, JR., M.D., AND LAWRENCE E. HOLDER, M.D., F.A.C.R.

Dr. Dowe is a second-year radiology resident and Dr. Holder is a professor of radiology and director of the division of nuclear medicine in the department of diagnostic imaging at the University of Maryland Medical Center. ■

Book Reviews

Physicians in Managed Care: A Career Guide. Mark A. Bloomberg, M.D., M.B.A., F.A.C.P.E., and Steven R. Mohlie, M.D., M.B.A. (eds). Tampa, FL: American College of Physician Executives; 1994. 152 pages. ACPE member: $20; nonmember: $25 (paper).

This book was written to provide a resource for those who wish to learn how physicians participate in managed health care organizations (MHCOs). Previous knowledge is not assumed, and this book is particularly intended for the clinician who is considering leaving direct patient care to enter the world of medical management.

Fourteen authors contributed to 12 chapters that explain what managed care is and what roles are available to the clinician, physician educator, and physician manager. Each chapter lists references for further exploration, and there is a section that provides information about the contributors.

The impact of managed care on clinical practice is examined, including payment mechanisms, autonomy, patient satisfaction, and quality/cost measurement. Skills needed to make the transition from clinician to manager are reviewed together with predictors of success. Characteristics of practitioners sought by MHCOs are identified, along with some of the tools that can be used to help meet the challenge of managing physicians. The pros and cons of making the career change from clinician to administrator are outlined, and available career paths are discussed from entry level through middle management to senior management positions.

The history of managed care is reviewed from the earliest prepaid group practices and health maintenance organizations through current organizational arrangements. The differences between MHCOs are examined with emphasis on how changing managerial positions between different models of managed care organizations can present important challenges to the physician executive. Future directions likely for MHCOs in America, their involvement in medical education, and how they may affect physicians in managed care are discussed.

The initial phase of a major reform process is already in progress and affecting our complex health care industry. Physicians have a great responsibility to help lead in the changes that must occur to create a health system that meets the needs of all Americans in an affordable manner. The experience shared by the authors and presented in this book can serve as an ongoing reference to those interested in the managed care field.

MARILYN S. RADKE, M.D., M.P.H.
LaPlata, Maryland

■ ■ ■

The PDR Guide to Women's Health and Prescription Drugs. Medical Economics Data. Montvale, NJ: Medical Economics Data; 1994. 891 pages. $24.95 (paper).

It has only recently come to the public's attention that women's health issues have taken a back seat to those of men in our country. Lack of basic research in the female aspects of heart disease is the most glaring example.

The PDR Guide to Women's Health and Prescription Drugs encourages women to take more control of their own well-being by obtaining knowledge of common diseases and basic disorders unique to women. The book also contains useful information on family planning, pregnancy, menopause, emotional problems, proper diet, and even plastic surgery.

The first half of the book is devoted to diseases and disorders women are more likely to experience. Chapter One begins with common disorders of the reproduc-

tive system; this is quite appropriate, as the female reproductive system is what brings most women into contact with the medical profession. Part One is interspersed with frequent illustrations as well as crucial information specific to the issue being covered. It also explains what to expect during an examination by a physician and describes diagnostic procedures as well as treatment options and follow-up care.

The book does not deal with diseases common to both men and women, such as gallbladder disease, kidney disease, and diabetes. Readers are expected to search elsewhere for information on these topics.

Part Two of this women's guide covers commonly prescribed medications and includes information specific to each drug and possible side effects. A chart is also included that addresses drug risks during pregnancy.

The end of this highly useful resource contains a list of support groups and means of contacting them.

This book is a practical and easily comprehensible guide for women aged 18 to 80. Even members of the medical profession are sure to learn something new about the care of women from this excellent manual.

LYNDA ARTUSIO, R.N.
Frederick, Maryland

■ ■ ■

Keeping Control. Understanding and Overcoming Fecal Incontinence. Marvin M. Schuster, M.D., and Jacqueline Wehmueller. Baltimore: The Johns Hopkins University Press; 1994. 166 pages. $29.95 (hardcover); $12.95 (paper).

Normal bowel function permits a pleasant life, but when voluntary influence over the anal sphincter is lost, daily existence may become hideous. Fear of such an accident may lead to shame, loss of self-esteem, and resultant social, sexual, and work disability.

Written in simple prose, *Keeping Control* is intended for and should be easily understood by the medically untutored. The first author, Dr. Schuster, is professor of medicine and psychiatry at The Johns Hopkins University School of Medicine and director of the division of digestive diseases at Hopkins Bayview Medical Center. His co-author, Ms. Wehmeuller, is a writer and editor at the Johns Hopkins University Press. The contents of the book should have a particular appeal to those afflicted with fecal incontinence, their relatives, and members of support groups concerned with bowel incontinence and dysfunction. Although physicians as a group may be cognizant of the book's contents, they too may find information that provides a newer view on the subject.

Approximately 1% of the general and 30% of nursing home populations have fecal incontinence. People with restricted mobility are particularly prone to suffer this affliction. Fecal continence is jeopardized by any injury, disorder, or disease that interferes with the factors that maintain this function. Neuromuscular impairment, immobility, or mental indifference associated with senility also may cause incontinence. A history of loss of sphincter control is not often volunteered and may even be withheld. Stains on clothing may be ignored and soiled clothing may be hidden.

Because other conditions may produce the same symptoms, the physician should obtain a meticulous medical history. Diagnosis may be facilitated by the patient's keeping a detailed symptoms diary of these untoward events. Although the patient may seek help primarily from the family doctor, better treatment will be obtained from a specialist in alimentary diseases. A carefully taken medical history; a good physical examination, particularly directed toward the anal sphincter; and selected diagnostic tests will usually unearth the cause of the difficulty.

Childhood encopresis, in the absence of demonstrated physical defects, is best treated by a caring, loving relationship with the parents and the avoidance of coercive toilet training. Adult support is needed for

To Our Readers

The Editorial Board of the *Maryland Medical Journal* invites you to submit reviews of books, videos, and films of interest to the medical profession. Bringing your evaluation and analysis to the attention of your colleagues will be informative and stimulating. Send your report to: Chris Papadopoulos, M.D., Book Review Editor, *Maryland Medical Journal*, 1211 Cathedral Street, Baltimore, Maryland 21201.

these youngsters to help them through a stressful period of their lives.

Older patients, in whom a treatable medical syndrome is not present, may derive considerable benefit from behavioral modification techniques. Two highly successful methods are biofeedback training and habit training. The crux of such training is the recognition by the patient that continence is a learned automatic response. When the internal sphincter relaxes, a signal is forwarded that defecation is necessary. The proper response is closure of the external sphincter, a voluntary function, to prevent involuntary loss of stool.

Biofeedback is clinically most effective when simpler sphincter exercises are unavailable. Initial rectosphincter manometric studies may define the disease present and provide the basis for biofeedback therapy. Successful results have followed one or two such treatments.

Surgical correction of anal deformity may be offered to some individuals. Gaps in the external sphincter from the time of delivery of trauma to the perineal floor may lend themselves to surgical repair by excision of the scar and reunion of the muscle. The results following these procedures or the insertion of a ring in the anal opening have generally been poor.

If medical or surgical treatment does not achieve an optimal result, the severity and frequency of accidents may be decreased using measures such as training, diet changes, and enemas.

The primary message of this book for the person with fecal incontinence is that the quality of life can be improved. Some restructuring of the psyche and life cycle may be necessary. Even if all of the desired results are not achieved, alleviation of some distress may be obtained. The patient learns what to do and how to act if an accident occurs. The motto for these people is "Be Prepared."

Fecal Incontinence should certainly be available in all medical libraries. It has an excellent glossary, a list of resource help groups, and a good index. The book is enthusiastically recommended to all concerned.

JOSEPH M. MILLER, M.D.
Timonium, Maryland ■

Tips for evaluating warfarin food and drug interactions:

- Be sure warfarin dosage and anticoagulation level are stable before starting a drug that may interact with it.
- Do not conclude there is no interaction unless the potentially interacting drug has been given in typical clinical doses long enough to have reached a substantial plasma level.
- Do not assume a hemorrhagic complication is due to an interaction unless coagulation measures indicate a change in warfarin dosage is required.
- Rule out other causes that could alter coagulation measures (e.g., increased dietary vitamin K, hepatic dysfunction, hypermetabolic states).

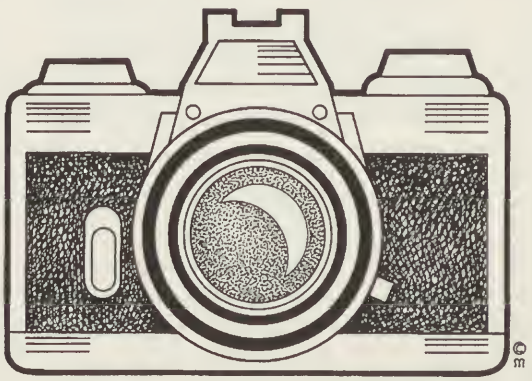
Reference

Wells PS, Holbrook AM, Crowther NR, Kirsch J. Interactions of warfarin with drugs and food. *Ann Intern Med* 1994;121:676-683.

Enter the Fifteenth Annual Med Chi PHOTO CONTEST!

Contest is open to all Med Chi and Alliance members.

Two categories: black & white OR color with first and second prizes awarded in each category.



Deadline for entries is Friday, March 17, 1995.

All entries will be displayed at the 1995 annual meeting at the Inn and Conference Center, College Park.

Photo Contest Rules:

Eligibility: All members of Med Chi and members of the Alliance may enter. Professional photographers may not enter.

1. Photographs may be submitted in two categories: black and white OR color.
2. Limit: three entries per person.
3. Prints only; prints smaller than 8" x 10" or larger than 11" x 14" will not be accepted. If your favorite shot is a slide, you must have a print made within this size range to enter the contest.
4. Entries must be matted or dry mounted. No framed photographs will be accepted.
5. Entries must have name, address, and telephone number attached to the back of each photograph.
6. Entries may be mailed or brought to Med Chi, 1211 Cathedral Street, Baltimore, MD 21201 by 5:00 pm on March 17.
7. Photographs entered in the contest will be on display at the 1995 annual meeting.
8. Prizes will be awarded to the first and second place winners in each category.
9. Winners will be announced at the annual meeting of the Medical and Chirurgical Faculty, May 4-6, 1995.
10. Photographs will not be mailed back. They may be claimed at the registration desk at the close of the annual meeting at noon on May 6 or at Med Chi thereafter.
11. Med Chi does not guarantee against loss or damage of any kind to the photographs submitted to the contest.

Alliance

The Medical Society Alliance of Anne Arundel County and Sarah's House

Sarah's House, Anne Arundel County's shelter for the homeless, was recently presented with a new Dodge van by the Medical Society Alliance of Anne Arundel County. The van was purchased with money raised through the Professional Courtesy Fund, which was set up in 1989 as an adjunct to the Holiday Sharing Program. Holiday Sharing is a joint effort between the Department of Social Services (DSS) and the Medical Society Alliance of Anne Arundel County. The program matches donors with needy families at Thanksgiving and Christmas.

Each year in mid-October, a letter is sent to all physicians in Anne Arundel County suggesting that in lieu of a gift (e.g., a poinsettia or fruit basket) to a colleague expressing appreciation for professional courtesy extended to family members, they send a donation to Sarah's House courtesy fund. A thank you card is sent to everyone named by each donor and an acknowledgement is sent that can be used for tax purposes. The DSS covers operating and mailing costs and Alliance members take care of all paper work. The funds, which are held in a lay account at the DSS, are dispersed at the discretion of the DSS director and the Alliance chairperson of the Holiday Sharing Program.

Over the past five years, these funds have totaled over $28,000. They have been used to

- start an after-school tutoring program for the children living at Sarah's House;
- build a playground/picnic area between two of the buildings used by the families in residence; and
- purchase park benches, materials for picnic tables, tricycles, high chairs, and a TV/VCR that has been used for educational programs at the on-site daycare center and parenting classes.

Funds were set aside for the past three years to reach our goal of providing the new van. Funds are also set aside each year to be used for enrichment programs or to cover the cost of transportation when outside groups provide tickets to circus or theater performances.

Why Sarah's House?

Located in eight refurbished Army barracks at Fort George G. Meade, Sarah's House began services to the poor in the spring of 1987. Reflecting the cooperative spirit of Anne Arundel County, The U.S. Army, and Associated Catholic Charities, Sarah's House bridges the gap for the many men, women, and children in need of emergency services, medical attention, and legal assistance.

Meeting the needs

Through emergency shelter services and the following supportive and rehabilitative services, Sarah's House addresses the underlying causes of homelessness: safe temporary shelter; case management; telephone accessibility; health screenings; AA/NA meetings; three meals daily; laundry facilities; educational programs; and transportation to housing, social service, and medical appointments.

Transitional housing

In 1990, Sarah's House opened a transitional housing building that allows families to stay for longer periods of time. This allows them to save money, secure employment, attend or complete job training, and seek permanent affordable housing to re-establish themselves back into their community.

IMELDA HERZINGER
The Medical Society Alliance of Anne Arundel County ■



Imelda Herzinger, Medical Society Alliance of Anne Arundel County, and Peter O'Grady, director of Sarah's House, with the van donated to the homeless shelter.

Some of the great leaders in medicine aren't doctors.

Not yet, anyway. Medical students from each of the AMA-MSS school chapters listed below took time away from library, lectures, and the lab to recruit fellow medical students to the American Medical Association. These young movers and shakers are already influencing the profession which they will inherit. And we salute them. Please congratulate the recruitment teams from each of these AMA-MSS chapters:

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University of South Alabama

Arizona
University of Arizona

Arkansas
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Loma Linda University
Stanford University
University of California, Berkeley
University of California, Davis
University of California, Irvine
University of California, Los Angeles
University of California, San Diego
University of California, San Francisco
University of Southern California

Colorado
University of Colorado

Connecticut
Yale University

District of Columbia
George Washington University
Georgetown University

Florida
Nova Southeastern University of the Health Sciences, College of Osteopathic Medicine
University of Florida
University of Miami
University of South Florida

Georgia
Emory University
Medical College of Georgia
Mercer University

Illinois
Chicago College of Osteopathic Medicine
Chicago Medical School
Loyola University of Chicago
Northwestern University
Rush Medical College of Rush University
Southern Illinois University
University of Chicago, Pritzker School of Medicine
University of Illinois

Indiana
Indiana University

Iowa
University of Iowa

Kansas
University of Kansas

Kentucky
University of Kentucky
University of Louisville

Louisiana
Louisiana State University, New Orleans
Louisiana State University, Shreveport
Tulane University

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Uniformed Services University
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Tufts University
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University of Michigan
Wayne State University

Minnesota
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University of Minnesota, Duluth
University of Minnesota, Minneapolis

Mississippi
University of Mississippi

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University of Missouri, Columbia
Washington University

Nebraska
Creighton University
University of Nebraska

Nevada
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New Jersey Medical School
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University of New Mexico

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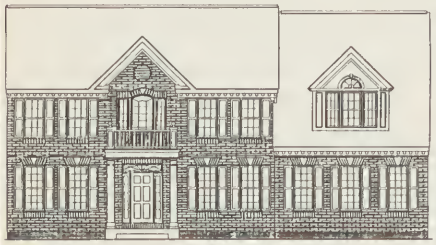
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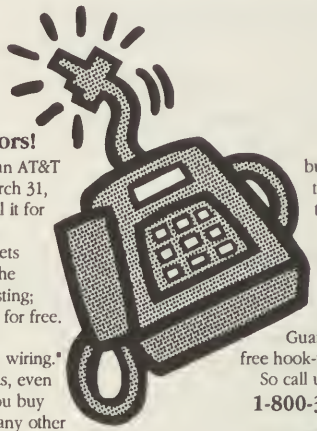
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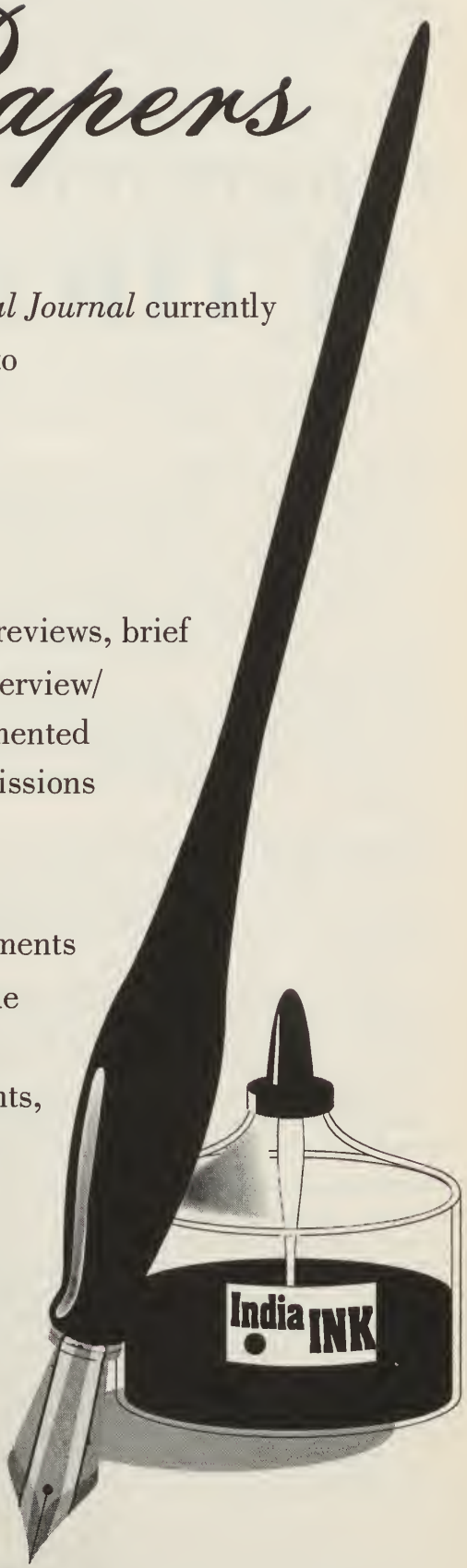
Call for Papers

The Editorial Board of the *Maryland Medical Journal* currently seeks original articles addressing topics related to

- Pain Management
- Patient Education
- Patients with Handicapping Conditions

Papers may be original research, literature reviews, brief reports, case histories accompanied by a brief overview/ summary of the relevant literature, or well-documented opinions about future trends. Deadline for submissions is February 15, 1995.

All submissions should conform to requirements listed on the "Information for Authors" page of the *Maryland Medical Journal.* For further information or to obtain a copy of submission requirements, contact Mary Ann Ayd, Managing Editor, 1211 Cathedral Street, Baltimore, MD 21201; 410-539-0872 or 1-800-492-1056; FAX 410-547-0915.



The Maryland Medical Journal (MMJ) *is a monthly publication of the Medical and Chirurgical Faculty of Maryland. The journal's goals are educational and informative: the publishing of scientific articles (original research, case studies, and review articles) and other technical information, as well as editorials, letters, special articles (evaluations, position papers, reviews of nonscientific subjects), membership and legislative news, continuing medical education notices, and programs and policies of the faculty.*

Information for AUTHORS

- ***Letter of transmittal***—The letter of transmittal, which all authors must sign, should include the full names, degrees, titles, and affiliations of all authors, and the name, address, and phone number of the author to whom reprint requests and correspondence should be sent.

  The letter should include a statement to the effect that all authors have participated in the conception and design of the work and in the writing of the manuscript, and that they take public responsibility for it. The authors should attest to the validity and legitimacy of the data, and acknowledge that they have reviewed the final version of the manuscript and approve it for publication.

  In addition, the letter must include a paragraph that transfers copyright ownership to the *MMJ* in the event that the work is published.

- ***Manuscript preparation***—Manuscripts should be submitted to Editor, *MMJ*, 1211 Cathedral Street, Baltimore, MD 21201-5585. Manuscripts must be original material not previously published and not under consideration by another publication. An abstract of 100 to 300 words is required.

  All material, including references, tables, and legends, must be double-spaced. Pages should be numbered. (All abbreviations should be spelled out on first use.) The original manuscript plus one copy should be submitted on standard (8.5" x 11") bond paper. If at all possible, an IBM-compatible disk should be included, with the manuscript entered in a WordPerfect, Multimate, Wordstar, or ASCII format; the transmittal letter should identify the format used.

- ***References***—References are limited to those citations noted in the text. References should be numbered consecutively as they appear in the text and should be kept to a minimum (fewer than thirty-five). Personal communications and unpublished data are not acceptable. At a minimum, references should include names of all authors, complete title of the article cited, name of journal abbreviated according to *Index Medicus* (if abbreviation is not known, journal name should be spelled out fully), year of publication, volume number, and first and last page numbers. Sample references are as follows:

  1. Stevens MB. The clinical spectrum of SLE. Md Med J 1991; 10:875–85.
  2. Ropes MW. Characteristics, manifestations, and pathologic findings. In: Ropes MD, ed. Systemic Lupus Erythematosus. Cambridge, MA: Harvard University Press. 1976; 50–4.

- ***Tables***—Tables should be typed on separate sheets of paper, be numbered, and have a brief descriptive title. Data presented in tables should be self-explanatory and should supplement, not duplicate, the text; the Editor reserves the right to edit tables. Authors should be sure that statistics are consistent in both tables and text.

- ***Illustrations***—Illustrations include material that cannot be set in type. Photographic material must be submitted as high-contrast, glossy prints. Drawings and graphs must be done professionally in india ink on high-grade white drawing paper or be computer generated. Identification—including figure number, the title of manuscript, the name of corresponding author, and arrow indicating top—should be typed on a gummed label and affixed to the back of each illustration. Legends for illustrations should be typed on a separate page with numbers corresponding to those on the photographs or drawings. Recognizable photographs of patients are to be masked and should carry with them written permission for publication. Cost of printing color photographs must be borne by the author.

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Checklist

- ☐ Original manuscript and one copy.
- ☐ IBM-compatable disk in WordPerfect, Multimate, Wordstar, or ASCII.
- ☐ Everything double-spaced.
- ☐ Letter of transmittal, signed by all authors, that includes release of copyright, statement of authorship responsibility, title and affiliation of all authors, and identification and phone number of corresponding author.
- ☐ Abstract of 100 to 300 words.
- ☐ Permission-to-borrow letters for any previously published illustrations or tables

Miscellaneous meetings

Cardiovascular conference at Snowshoe, sponsored by the American College of Cardiology, at the Mountain Lodge Conference Center, Snowshoe, WVA. 14.5 Cat 1 AMA credits. Info: 800-257-4739. — **Feb. 6–8**

Fourth annual spring clinical nephrology meetings primary care nephrology program, sponsored by the National Kidney Foundation at the Sheraton Washington Hotel in Washington, DC. Info: 1-800-622-9010. — **March 24–25**

Clinical perspectives on violence conference, at Sheppard Pratt Conference Center, Baltimore, MD. 6 Cat 1 AMA/PRA credits. Fee: TBA. Info: Professional Education Programs, 410-938-4598. — **March 25**

Substance abuse '95: programs in policy and practice, at the George Washington University Medical Center. 5.5 Cat 1 AMA credits. Info: Martha Cosgrove, 202-994-4536. — **March 25**

Reflux and ulcer disease advanced laparoscopy course, at the George Washington University Medical Center. Info: Maria Gorrick, 202-994-4285. — **March 31**

Third world congress on stress, trauma and coping in the emergency services professions, at the Sheraton Inner Harbor Hotel, Baltimore, MD. Info: 410-730-4311. — **April 19–23**

Clinical innovations in OB/GYN ultrasound, sponsored by Meetings & Management Techniques Plus and The American Institute of Ultrasound in Medicine at the Lowes L'Enfant Plaza in Washington, DC. 14.5 Cat 1 AMA/PRA credits and 15 Formal Learning Cognates by ACOB/GYN. Info: Ann Boehme 516-561-4223. — **April 22–23**

Caring for the diabetic lower extremity: a practical approach for primary health care providers, sponsored by the American Diabetes Association at the Sheraton International Hotel, BWI Airport. 7 Cat 1 AMA credits. Fee: $125/physicians; $100/ACP members; $75/other health professionals. Info: 410-526-2900. — **April 28**

Third international symposium on maritime health, sponsored by the George Washington University Medical Center, at the Maritime Institute of Technology and Graduate Studies in Baltimore, MD. 14 Cat 1 AMA credits, $1,200 before Feb. 28, $1,350 after (includes lodging and some meals). Info: Karen Mayer, 202-994-3921. — **June 7–9**

2nd annual intensive review of internal medicine, sponsored by the George Washington University Medical Center, at the Washington Marriott Hotel, Washington, DC. Info: Deborah Grant 202-994-4285. — **June 7–10**

3rd annual board review in family medicine, sponsored by the George Washington University Medical Center, at the Marriott Crystal Gateway Hotel, Arlington, VA. 39 cat 1 AMA/AAFP credits. Info: Maria Gorrick, 202-994-4285. — **June 24–28**

Continuously throughout the year

Fluorescein angiography conference, sponsored by the Retina Center, Saint Joseph Hospital, Baltimore, MD, first and third Mondays of each month; 8:00–9:00 am. Fee: none. Info: R. Classon, 410-337-4500.

The Johns Hopkins Medical Institutions

All courses at the Thomas B. Turner Building unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Medical Education, 720 Rutland Ave., Baltimore, MD 21205 (410-955-2959).

Basic comprehensive endoscopic sinus surgery, Cat 1 AMA credits available. $850/labs and lectures; $325/lectures only.	**Dec. 8**
Advanced comprehensive endoscopic sinus surgery, Cat 1 AMA credits available. $1400/ labs and lectures; $495/lectures only.	**Jan. 13–14**
Advances in cardiac diagnosis and treatment 1995, at the Sheraton Baltimore North, Towson, MD. Cat 1 AMA credits available. Fee: TBA.	**Jan. 19–20**
Frontiers in research and clinical management of asthma and allergy, 14 Cat 1 AMA/AAFP credits available. Fee: $395/physicians; $275/residents, fellows and allied health professionals.	**Jan. 20–22**
Advances in cardiac diagnosis and treatment, 18 Cat 1 AMA credits.	**Jan. 20–22**
1995 Update in the management of age-related macular degeneration, 8 Cat 1 AMA credits. Fee: $225/physicians; $125/residents, fellows and allied health professionals.	**Jan. 21**
22nd Annual geriatrics symposium: primary care for the practitioner, at the Stouffer Harborplace Hotel, Baltimore, MD. 18 Cat 1 AMA credits available. $275.	**Feb. 2–4**
12th Annual Houston Evertt memorial course in urogynecology, 17 Cat 1 AMA credits.	**Feb. 24–25**
Pain treatment centers at a crossroads: a practical and conceptual reappraisal, 20 Cat 1 AMA credits. $350/physicians; $250/allied health professionals, residents, fellows.	**March 3–5**
Nuclear oncology, 16 Cat 1 AMA credits. Fee: $495/physicians; $395/residents, fellows, and allied health professionals.	**March 8–10**
Principles and practice of clinical MRI, at the Renaissance Hotel, Washington, DC. 21.5 Cat 1 AMA credits.	**March 23–26**
Fifth annual perspectives on clinical nutrition, 11 Cat 1 AMA credits.	**March 24-25**
Spectrum of developmental disabilities XVII, 20 Cat 1 AMA credits.	**March 27–29**
Diagnosis and treatment of neoplastic disorders, 13.5 Cat 1 AMA credits. $300/advanced registration (prior to 2/1/95); $325/registration; $150/residents, fellows, and allied health professionals.	**March 30–31**
36th Annual postgraduate institute for pathologists in clinical cytopathology, 136 Cat 1 AMA credits.	
Course A (Home Study)	**Feb–March**
Course B (Johns Hopkins Medical Institutions)	**April 3–14**
The care of patients with Alzheimer's and other dementias, at the Stouffer Harborplace Hotel, Baltimore, MD. 5.5 Cat 1 AMA credits available. Fee: $120/physicians; $75/residents, fellows, and allied health professionals.	**April 1**
23rd Annual pediatric trends, 42 Cat 1 AMA/AAP credits. $650/physicians; $450/residents and fellows.	**April 3–8**
Clinical care of the patient with HIV infection, at the Stouffer Harborplace Hotel, Baltimore, MD. 13 Cat 1 AMA credits.	**April 6–7**

The Johns Hopkins Medical Institutions (continued)

Current concepts in thyroid disease: update 1995, 8.5 Cat 1 AMA credits. $160/physicians; $30/residents and fellows.	**April 21**
Ninth annual mood disorders symposium, Cat 1 AMA credits pending. $50/DRADA members; $60/other.	**April 25**
Wilmer nursing conference	**April 28**
Pediatric allergy and immunology for the practitioner, 14.5 Cat 1 AMA credits.	**May 4–5**
Contemporary issues in the diagnosis and treatment of low back pain	**May 4–6**
In vitro toxicology	**May 8–10**
Rheumatology nursing	**May 12–13**
40th Annual topics in clinical medicine, 40 Cat 1 AMA credits.	**May 15-19**

Continuously throughout the year

Visiting preceptorship in pediatric critical care medicine. Ongoing five-day preceptorship by appointment. 40 Cat 1 AMA/PRA credits. Fee: $600.

The department of radiology and radiological sciences offers several courses in abdominal and obstetrical ultrasound. Info: P. Williams, 410-955-3169.

Visiting physicians. Offered throughout the year for experience in the lab and participation in read-in sessions; by appointment only. 40 Cat 1 AMA/PRA credits. Fee: $500.

Johns Hopkins medical grand rounds. Accredited audiovisual continuing education series of case discussions for clinicians; 30 topics per year in five bimonthly programs. Individual and group subscriptions. 40 Cat 1 AMA/PRA credits. Info: 410-955-3988.

Johns Hopkins sports medicine grand rounds. Accredited continuing education series of case discussions by a different presenter on the first Thursday of each month. Info: Carol Kelly, 410-383-0600.

PHYSICIAN'S RECOGNITION AWARD

During November 1994, the physicians listed below received the American Medical Association Physician's Recognition Award. Established in 1968, the award's purpose is to encourage physician participation in continuing medical education and to recognize those physicians who have voluntarily completed programs of continuing medical education.

Leon A. Adams, M.D.
Jay M. Grodin, M.D.
Ronald E. Keyser, M.D.
K. Kumarachandran, M.D.
George E. Linhardt, M.D.
Darshan S. Saluja, M.D.
Arthur A. Serpick, M.D.
Marcia W. Waterbury, M.D.

University of Maryland

For each course, additional information may be obtained by contacting the Program of Continuing Education, University of Maryland School of Medicine, Room 14-011, BRB, 655 W. Baltimore St., Baltimore, MD 21201 (410-706-3956) or by calling the phone number listed after a specific program. FAX 410-328-3103.

Physician forum HIV: substance abuse disorders in the HIV-infected patient— management issues for the care provider, at the Brass Elephant Restaurant in Baltimore, MD. 1 Cat 1 AMA credit. Info: Sylvia Scherr, 410-328-8639. — **Jan. 19**

Maryland Otolaryngology, Head & Neck Surgical Society: evaluation & treatment of patients with chronic sinusitis, Baltimore, MD. 3 Cat 1 AMA credits, Fee: $165. Info: J.F. Biedlingmaier, M.D., 410-225-8072. — **Feb. 21**

Physician forum HIV: HIV care provision—medical, legal, and ethical dilemmas, at the Brass Elephant Restaurant in Baltimore, MD. 1 Cat 1 AMA credit. Info: Sylvia Scherr, 410-328-8639. — **March 16**

Maryland Otolaryngology, Head & Neck Surgical Society: resident research presentations, at the Greater Baltimore Medical Center, Towson, MD. 3 Cat 1 AMA credits, Fee: $165. Info: J.F. Biedlingmaier, M.D., 410-225-8072. — **April 25**

8th Annual trauma anesthesia & critical care symposium, at the Hyatt Regency Hotel in Baltimore, MD. Cat 1 AMA credits. Info: Kimberly Unitas, 410-328-2399. — **May 11–13**

Physician forum HIV: beyond the recommendations—how we really care for AIDS patients, at the Brass Elephant Restaurant in Baltimore, MD. 1 Cat 1 AMA credit. Info: Sylvia Scherr, 410-328-8639. — **May 18**

21st Annual family medicine review course, at the Princess Royale Ocean Suite Hotel in Ocean City, MD. Cat 1 AMA/AAFP credits. Info: Althea Pusateri, 410-706-3956. — **June 25-30**

PHYSICIAN PLACEMENT SERVICE

The Medical and Chirurgical Faculty of Maryland maintains a Placement Service for the convenience of Maryland physicians, hospitals, and communities in search of candidates for positions available in our state. A detailed description of such opportunities should be forwarded to:

Physician Placement Service
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Baltimore, MD 21201
410-539-0872
1-800-492-1056

Physicians wishing to locate in Maryland are invited to submit a résumé to be kept on file with the Physician Placement Service. Candidates are requested to inform the Faculty when they are no longer available for consideration opportunities in Maryland.

MMJ announcements for physician placements in the classified advertisements are charged at the regular classified advertising rate.

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DHMH Maryland Department of Health & Mental Hygiene

Nelson J Sabatini - Secretary
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J Mehsen Joseph, PhD - Director
Community Health Surveillance & Laboratories Admin

Ebenezer Israel, MD, MPH- Director
Epidemiology & Disease Control Program

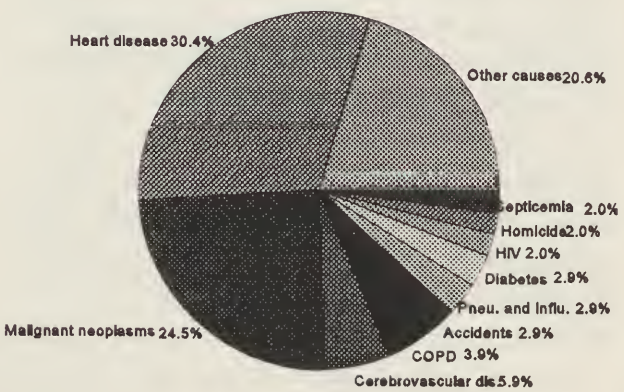
EPIDEMIOLOGY & DISEASE CONTROL PROGRAM
201 W. Preston Street, Baltimore, Maryland 21201 (410)225-6700

January, 1995
Cardiovascular Disease in Maryland
The Maryland Prevention and Control Plan

The Maryland Advisory Council on High Blood Pressure and Related Cardiovascular Risk Factors was created by law to advise the State on cardiovascular disease (CVD) policy. It is composed of 15 individuals representing the public and 10 health related organizations.[1] This council, with the help of expert committees, has recently reviewed and analyzed National and State CVD data, reviewed the literature on prevention and control of CVD, and formulated policy recommendations for CVD. The result of this effort - The Maryland Cardiovascular Disease Prevention and Control Plan was discussed at the Maryland Cardiovascular Summit held in Baltimore, Maryland on November 3, 1994.

The Plan identified CVD, coronary heart disease, and stroke as the leading cause of death and source of health care costs in Maryland. Figure 1 shows that these two causes of death accounted for 36% of all deaths in Maryland during 1992.

Figure 1
Leading Causes of Death
Maryland, 1992

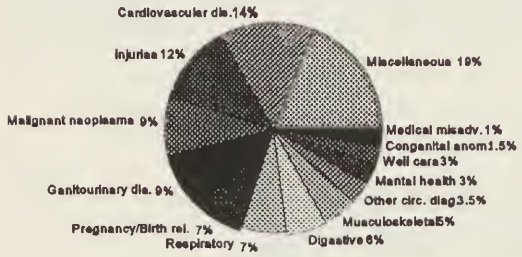


Source: Maryland Vital Statistics 1992
Preliminary Report

CVD accounted for 14% of all medical care expenditures in the U.S. in 1987 and is also the most costly disease category (Figure 2).

[1]The American Heart Association - MD Affiliate, Inc., Johns Hopkins Medical Institutions, Maryland Conference of Health Officers, Maryland Department of Health and Mental Hygiene, Maryland Hospital Association, Maryland Nurses Association, Medical and Chirurgical Faculty, Monumental City Medical Society, Statewide Health Coordinating Council, and University of Maryland Hospital and School of Medicine.

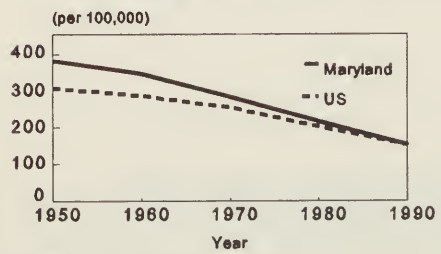
Figure 2
Percent Distribution of Medical Spending* By Diagnostic Categories, U.S., 1987



*Includes services other than nursing-home care, dental care and insurance claims processing.
Source: MMWR, August 19, 1994.

The Plan described the trends in heart disease and stroke mortality over the last 40 years. Since 1950, there has been a steady decline in heart disease mortality both in Maryland and the U.S. By 1990 the Maryland rate which had always been higher than the U.S. rate dropped to the same level as the U.S. (Figure 3). Despite the declines, this rate still does not meet the Healthy People 2000 objective for the nation of 100 per 100,000 population.

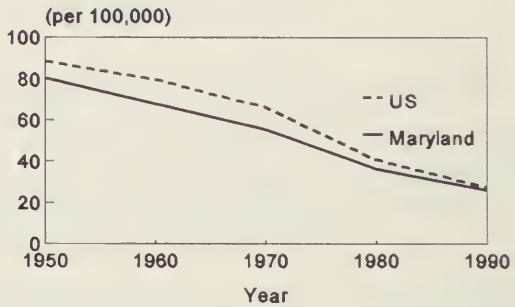
Figure 3
Age-adjusted Heart Disease Mortality Rates Maryland and the U.S.



Source: NCHS Vital Statistics, 1950-90

Since 1950, there has also been a steady decline in stroke mortality both in Maryland and the U.S. Unlike heart disease, Maryland has always had a lower stroke mortality than the U.S. rate (Figure 4). The current rates for both Maryland and the United States do not meet the Healthy People 2000 objective for the nation of 20 per 100,000 population.

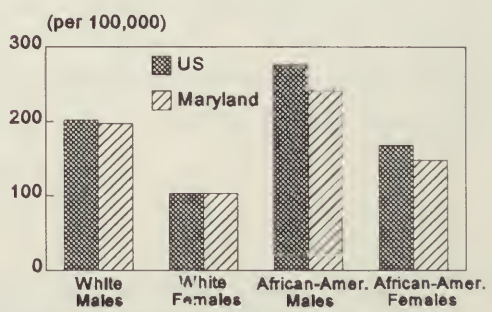
Figure 4
Age-adjusted Stroke Mortality Rates Maryland and the U.S.



Source: NCHS Vital Statistics, 1950-90

The Plan pointed out that men have a higher heart disease mortality rate than women and African-Americans have a higher mortality rate than whites (Figure 5).

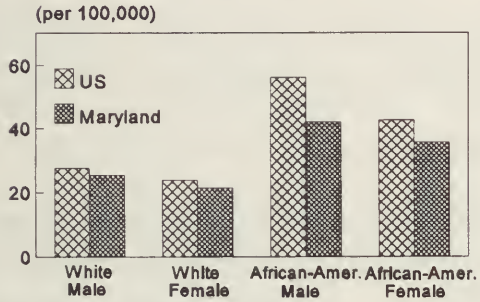
Figure 5
Age-adjusted Heart Disease Mortality by Race-Sex, 1990



Source: NCHS Compressed Mortality File, 1990

Men overall have a slightly higher mortality rate of stroke than women, especially African-American men. African-Americans overall have a higher rate of stroke than whites, especially African-American men (Figure 6).

Figure 6
Age-adjusted Stroke Mortality Rates by Race-Sex, 1990



Source: NCHS Compressed Mortality File, 1990

Excess mortality in Maryland's African-American population compared to whites appears to be largely attributable to a higher prevalence of high blood pressure, overweight, and diabetes (Table 1).

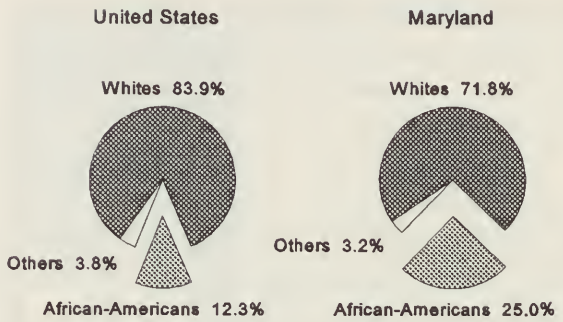
Table 1
Prevalence Rates of CVD Risk Factors by Race
Maryland, 1987-91

Health Status Indicators	White	African-American
Smoking	23.4	24.2
High Blood Pressure	20.4	26.1
High Blood Cholesterol	24.4	19.1
Diabetes	3.7	6.2
Sedentary Lifestyle	59.2	66.4
Overweight	21.7	33.8
Chronic Drinking	4.5	2.3

Source: Maryland BRFS, 1987-1991

Finally, Maryland as compared to the U.S. has a greater proportion of African-American citizens (Figure 7).

Figure 7
Population Distribution by Race 1990



Source: U.S. Bureau of Census, 1990

The increasing proportion of African-Americans in the Maryland population helps to explain why overall Maryland stroke mortality rates are now the same as the U.S. rates (Figure 4)

The CVD Plan also identified efficacious modalities that will reduce CVD mortality in Maryland and gave priority to five modalities that will have the greatest impact on mortality reduction. Of highest priority is reduction of saturated fat in the diet. Prevention of cigarette smoking, increased physical activity, obesity reduction, and caloric reduction were identified as important ways of significantly reducing premature CVD deaths. These priorities were established by the Council's Scientific Committee chaired by David Levine, M.D., Sc.D., M.P.H. of Johns Hopkins.[2]

To implement these modalities statewide, the Plan identified five priority channels. These are worksites, schools, health practice sites, grocery stores, and community outreach and social networks. At the CVD Summit participants were divided into work groups related to each priority channel. These work-groups began the process of identifying the essential components of a CVD program within

[2]The other members of the Committee were Daniel E. Ford, M.D., M.P.H., Moyses Szklo, M.D., Dr.P.H., and Paul K. Whelton, M.D., M.Sc. of Johns Hopkins and Roger Sherwin, M.D. and Donald Fedder, Dr. P.H., M.P.H., of the University of Maryland School of Medicine.

each channel as the first step in developing action plans.

Finally, the CVD Advisory Council made three major policy recommendations at the November CVD Summit and in the State Plan. These are as follows:

Recommendation 1:
Primarily prevent CVD through comprehensive lifestyle modifications beginning in childhood as the highest priority:

- Reduce serum cholesterol levels in the entire Maryland population by increasing healthy eating, namely, by lowering total fat and saturated fat and raising fiber intake.

- Increase physical activity in the entire Maryland population.

- Reduce the prevalence of type II diabetes in Maryland by a reduction in caloric intake and an increase in physical activity in the entire population.

- Reduce blood pressure levels in the entire Maryland population with special emphasis on African Americans by decreasing calorie, sodium, and alcohol intake in the diet and increasing physical activity.

- Reduce initiation of cigarette smoking in the entire Maryland population.

Recommendation 2:
Secondarily reduce the CVD burden through lifestyle change and treatment of CVD-related medical conditions in individuals with medical risk factors for CVD, or who are otherwise at higher risk for CVD due to family history, racial/ethnic background, prior stroke or heart attack, or poor availability of adequate medical care.

- Reduce blood pressure levels in individuals consistent with national guidelines and with emphasis on African Americans.

- Reduce elevated blood cholesterol levels in younger adults (without manifest coronary heart disease) through lifestyle modification.

- Reduce blood cholesterol levels in individuals who have had myocardial infarction or who have coronary artery disease through lifestyle modification and, if necessary, medication.

- Reduce smoking in all adults, especially those with high blood pressure, high blood cholesterol, diabetes, obesity, and sedentary lifestyles.

- Reduce the prescribing of medication that is contraindicated if CVD risk factors are present:
  - oral contraceptives in smokers,
  - medications that raise cholesterol in individuals with elevated cholesterol.

Recommendation 3:
- Develop and coordinate a comprehensive implementation strategy for CVD prevention and control for all Maryland residents that combines a population approach directed to children and young adults with a high-risk approach directed to high-risk individuals and their families.

Acknowledgement: Special thanks to the authors, Elijah Saunders, M.D., F.A.C.C., Chairman, Maryland Council on High Blood Pressure & Related Cardiovascular Risk Factors (MCHBP/RCRF), Rex Archer, M.D., M.P.H., Vice-Chairman, MCHPB/RCRF, Donald Fedder, Dr.P.H., M.P.H., and David Stewart, M.D., M.P.H.

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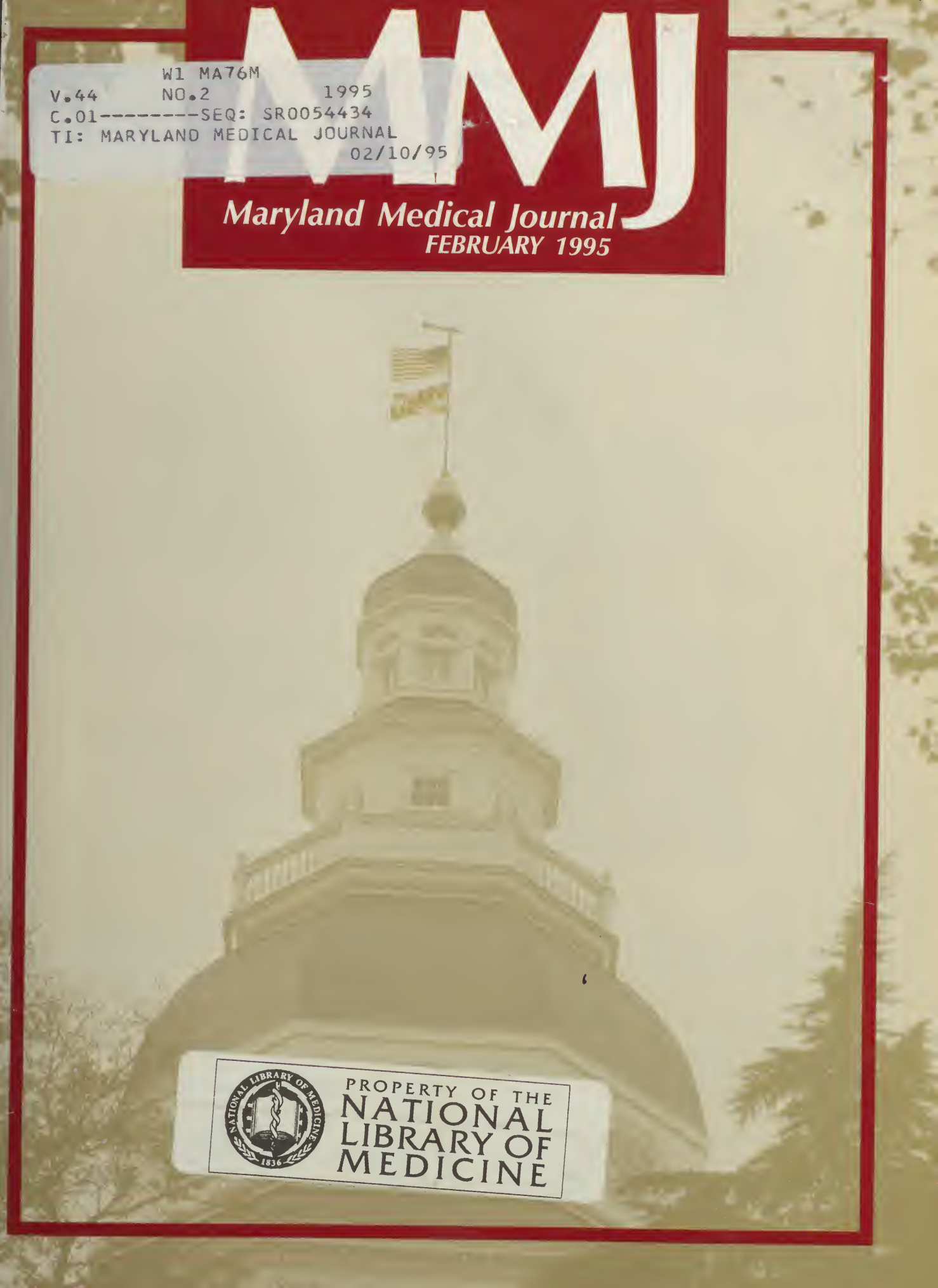
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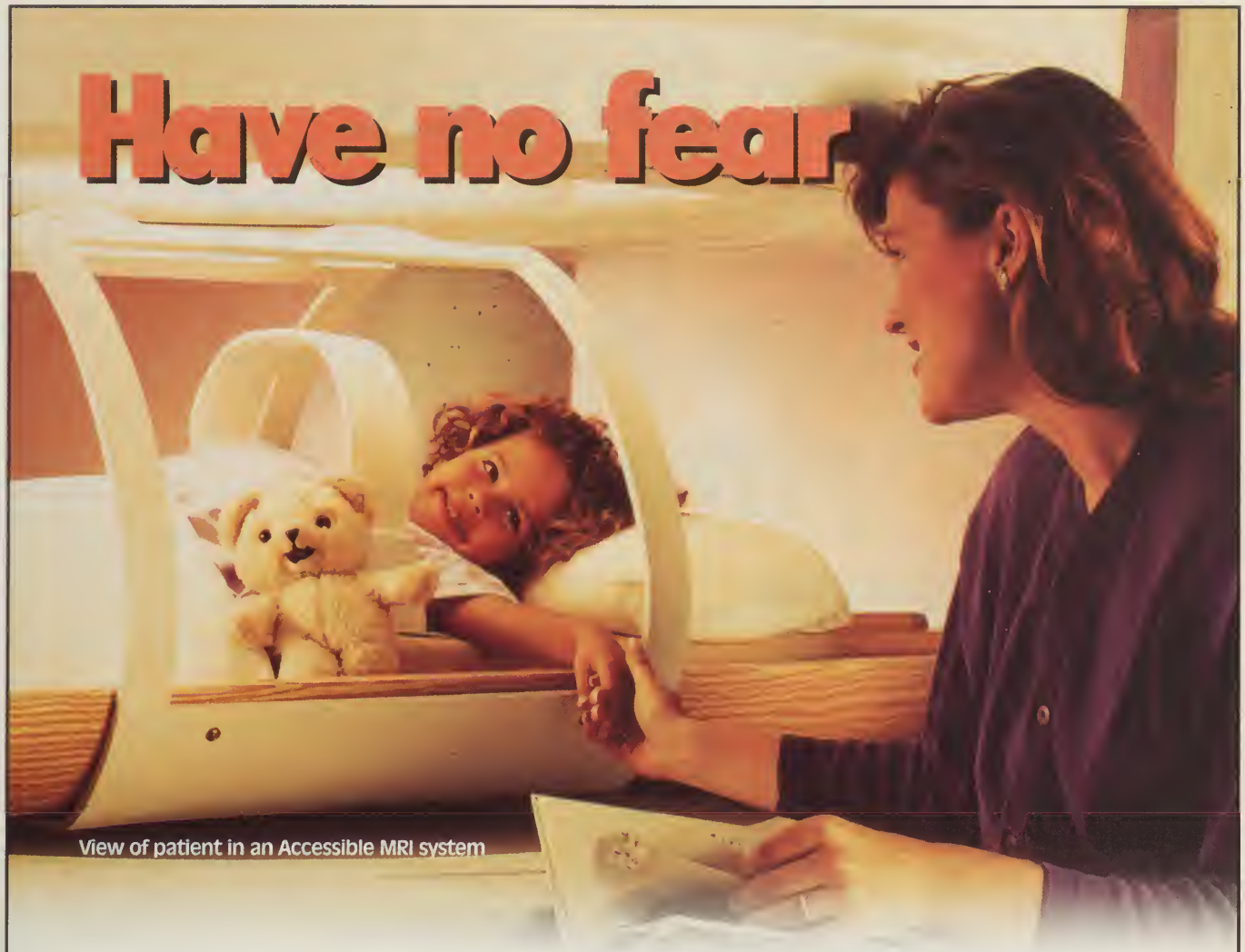
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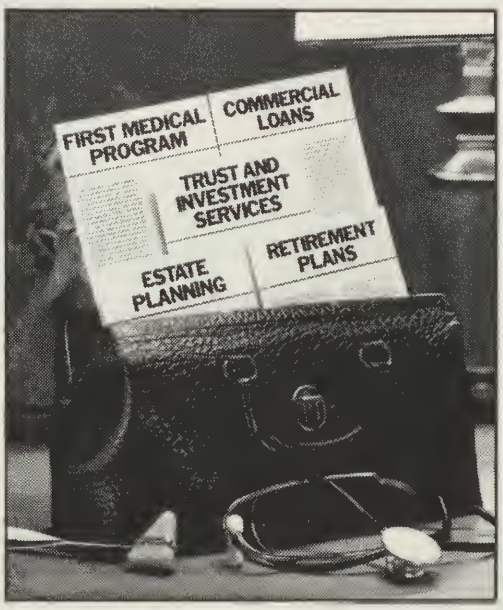
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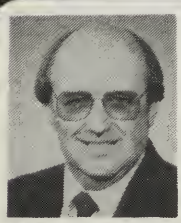
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1995 Med Chi Membership Directory

The *1995 Med Chi Membership Directory and Allied Health Professional Listing* was mailed to all active Med Chi members with this February 1995 issue of the *Maryland Medical Journal.* If your membership status is emeritus, emeritus-at-large, affiliate, associate, student, or resident, you can request a free copy of the directory by calling Wanda Griebel at 410-539-0872 or 1-800-492-1056, ext. 330. The directory is available to non-Med Chi members for $250 plus postage.

A Fable for Reform

Immediately following this issue of the *Chief Executive Officer's Newsletter* is a speech given by AMA President Robert E. McAfee, M.D., at the Interim Meeting of the AMA House of Delegates held in December. Entitled "King Will and the Foul Humours: A Fable for Reform," it is a unique look at the state of federal health system reform.

Maryland Insurance Administration Denies BlueCross BlueShield Reorganization Plan

On January 23, 1995, Insurance Commissioner Dwight K. Bartlett released his ruling dated January 20, 1995, which denied approval of the restructuring plan submitted by BlueCross BlueShield of Maryland (BCBSM) to the Maryland Insurance Administration on October 28, 1994. The restructuring as proposed by BCBSM would have created a for-profit subsidiary that would own all BCBSM's current health maintenance organizations and third-party administrator Willse & Associates. The plan also proposed the formation of an indemnity insurance company and an insurance sales agency. Med Chi representatives President Donald H. Dembo, M.D., General Counsel Angus R. Everton, Esq., and Controller Glen Burger testified against the proposed restructuring during a hearing held by the insurance administration on December 19, 1994.

In his ruling, Commissioner Bartlett acknowledged that "there was a wide divergence of opinion" expressed during the hearing and in the subsequent written communications that his office received. "I have carefully reviewed all the information provided to me before, during and after the hearing," he wrote in his ruling. " This review convinces me that the proposal may not be approved under Maryland law for two reasons. First, the proposed reorganization will clearly have the result of transforming the overall organization into an enterprise whose for-profit activities are no longer incidental to the nonprofit purposes of BCBSM....Second, as filed, the proposal is riddled with conflicts of interest between the dominant for-profit subsidiary and the soon to be secondary nonprofit parent." Concern about the potential conversion to a for-profit entity, and potential conflicts of interest were expressed by Med Chi and a number of other witnesses during the hearing.

BCBSM can appeal the ruling or file a revised reorganization plan with the insurance administration.

Med Chi Testifies Against BlueCross BlueShield Proposed Fee Schedule

In response to a filing by BlueCross BlueShield of Maryland (BCBSM) to change the way it reimburses physicians, the Maryland Insurance Administration held public hearings on January 9 and 10, 1995. Representatives of Med Chi and several specialty societies, as well as individual practitioners, testified against the proposed rate structure, saying that its implementation could adversely affect patient care and the cost of health care throughout the state.

In a news release about the hearings, BCBSM stated: "The insurer is now seeking to convert to a Resource Based Relative Value Unit (RBRVU) system which bases physician reimbursement on the complexity of actual procedures. The proposed changes would result in increases in reimbursement for primary care providers, such as family practitioners, internists and pediatricians. Many specialty providers would see decreases in reimbursement which follow national trends."

Testifying at the hearings on behalf of Med Chi were President Donald H. Dembo, M.D., Legislative Committee Vice Chairperson Howard L. Siegel, M.D., General Counsel Angus R. Everton, Esq., J. Leonard Lichtenfeld, M.D., and Chief Operating Officer Roseanne M. Matricciani, R.N., J.D. Their testimony addressed the flaws in BCBSM's methodology and the fact that since BCBSM did not file a complete reimbursement schedule with the insurance administration, it was impossible to adequately assess its impact on health care in Maryland. Dr. Lichtenfeld, who has served for several years on the AMA's Relative Value Update Committee, disputed BCBSM's claim that the new fee schedule is a RBRVU system. He testified: "This is not RBRVS methodology. There is no single conversion factor that applies to all the services. If they are indeed using an RBRVS methodology, one would expect all services to be reimbursed using a single conversion factor." Mr. Everton testified, "The BCBSM proposal appears to lack the essential element of the Harvard model RBRVS, which is a coherent system of relative values for work, practice expenses and professional liability insurance." He asked that the insurance commission submit the payment proposal for analysis by an independent auditing or actuarial consultant at the expense of BCBSM.

Joseph W. Zebley, III, M.D., representing the Maryland Academy of Family Physicians, disputed BCBSM's claim that the proposed fee schedule would increase reimbursement to primary care providers. He testified: "An RBRVS system that expects to reduce payments to physicians 10-15% will not reimburse family doctors more—in fact, we will be lucky if we break even as we barely did under HCFA's RBRVS . . . . The numbers we have been shown are unreliable and the methodology used is cloaked."

In closing remarks after all public testimony had been heard, BCBSM representatives said the company had used multiple conversion factors (seven) in the proposed fee schedule so that the company could achieve a predetermined cost savings. They also stated that although BCBSM had not filed a complete fee schedule with the insurance administration, it was available. Commissioner Bartlett concluded the hearings by asking BCBSM to file the entire fee schedule with the insurance administration. He said he would delay ruling on the schedule until after the information was filed and reviewed by the administration. As of press time, no decision had been made regarding the fee schedule.

Fee Schedule

The 1995 Physician Fee Schedule updates are:

- 12.2% increase for surgical services;
- 7.9% increase for primary care services, which consist of office visits, nursing home visits, house calls, emergency room visits, and ophthalmology visits of new patients; and
- 5.2 % increase for other nonsurgical services (including anesthesia).

Physician Care Plan Oversight

Effective January 1, 1995, Medicare began making separate payment for care plan oversight services provided to Medicare home health agency and hospice patients. Payment is limited to one physician per patient per month if 30 or more minutes of oversight services are provided in the month.

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Effective January 16, 1995, providers may call the following telephone number to request a telephone review: 410-316-7599, 8:30 AM - 4:00 PM, Monday through Thursday, and 8:15 AM - 3:45 PM Friday.

Telephone reviews must meet the following criteria:

1. Reviews are limited to assigned claims only. (There may be instances when the provider requests a review on behalf of the beneficiary on a nonassigned claim if the beneficiary is present at the time of the request.)

2. Reviews on six claims per phone call will be accepted from each provider. (If the provider has more than six claims, TrailBlazer will take your name and telephone number and return your call to complete the reviews.)
3. The review constitutes a complete or full reversal. The review request must be made on a totally denied claim or detail line where no payment was made during original processing.

When requesting a telephone review, identify the claim you want reviewed and have the EOMB and all supporting documentation available to facilitate proper handling of your inquiry. All information given by phone will be fully documented and retained in Medicare's files. If the initial decision is changed, the EOMB will be sent as notice of the review determination; however, if the review cannot be handled over the phone, you will be asked to submit the request in writing.

The following instances meet the criteria for a telephone review on a totally denied charge or claim:

- procedure codes or description of service are missing or invalid;
- the procedure was denied due to incorrect place of service;
- the procedure is not covered for the provider type;
- type of service is missing or invalid;
- the service was not allowed for the diagnosis;
- specific dates of service are referred for each service;
- claim was denied due to insufficient information;
- modifiers are omitted; or,
- charge is a duplicate (provider indicates not a duplicate).

Claims only can be reviewed once. If your are dissatisfied after receiving an EOMB of an adjustment, submit further inquiries in writing.

Please note that multiple surgeries on the same date of service, medically reviewed services, and services that require manual pricing are excluded from telephone reviews.

TrailBlazer Health Enterprises, Inc. Update

TrailBlazer Health Enterprises, Inc. (THE) has begun processing Medicare Part B claims for Maryland. The following information is provided as of 1/12/95:

- 449,273 claims were received; 286,846 were electronically filed;
- 269,225 claims were processed and checks and EOMBs were mailed; 220,023 claims were paid and 41,150 claims were denied;
- claims are crossing over to other insurers; this can be identified by messages on the EOMB;
- claims processing timeliness rates are:

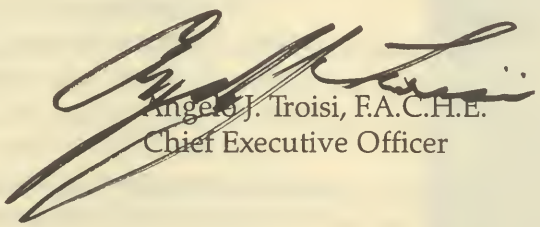
Paper Claims	99.1%	30 days
EMC Claims	99.9%	14 days

The receipt date is being counted from the day the claim was received by either BlueCross BlueShield of Maryland or THE;

- On Saturday, January 7, 1995, THE entered 25,000 paper claims in Texas to reduce the number of paper claims pending in Maryland;
- EOMBs and checks for run dates 1/5, 1/9, and 1/10 were mailed separately; and
- The provider telephone number on the automated development letter is incorrect. The correct number is 410-771-6111.

THE has published the following reminders for providers:

1. For consultations, you must provide the referring physician's name and UPIN except for confirmatory consultation.
2. E & M diagnoses codes are not appropriate for reporting the patient's diagnosis.
3. The psychiatric limitation applies to all services provided nonhospital in-patients if the patient is being treated for a psychiatric diagnosis.
4. Pre-operative exams should be billed using ICD-9-CM diagnoses codes V72.81 - V72.85.
5. Purchased tests: The list of procedures requiring a -WP modifier was published in Transition Newsletter 2. THE uses a -WP, not a -W2.
6. Dates of service cannot span two calendar months. If a patient has services in two different months, each month should be entered separately.



Angelo J. Troisi, F.A.C.H.E.
Chief Executive Officer

King Will and the Foul Humours: A Fable for Reform

Report of the President, Robert E. McAfee, M.D.
American Medical Association, 48th House of Delegates Interim Meeting

Ladies and gentlemen, over the course of the last two years, we've been asked to believe several fairy tales in the name of health system reform. So today, I'd ask your indulgence as I tell one last fairy tale. I'd like to tell you the story of King Will and the Foul Humours.

Once upon a time, there were a King and Queen who lived in a big, white castle, surrounded by a big, black fence, that was regularly patrolled by knights wearing dark visors.

Before King Will had become King, he lived in the forest, where he took from the rich and gave to the poor. This made him quite popular — especially with the poor — but he mistook his popularity for wisdom, and no sooner had he moved into the white castle than he began searching throughout the Kingdom for problems to solve.

He said to the Queen: "Queen (for he always addressed her in this manner) "do you perceive any problems in the Kingdom that criest out for solutions?"

The Queen replied: "Are you kidding? The knighthood could use a little more diversity. The plague is making a comeback. And every time you take your exercise, you can't stay away from the butcher shop."

Now, the King ignored this last comment, but the problem of the plague seized his mind. He knew that many of his subjects were unable to see the Wizards — those Doctors of Physic who ministered to the ill. And he knew that the tithe for having their humours checked was rising faster than the Consumer Price Index.

But the King also knew that the magic of the Wizards was unsurpassed. Citizens from neighboring kingdoms would travel many leagues just to see them. And the vast majority of his subjects were well contented with their system of care, and could see a Wizard almost whenever they wanted to.

The King mulled over his dilemma; he was famous for mulling and wonking and finally, he came to a decision. So he said to the Queen: "It is up to us to give the people the health care they deserve."

Now a strange thing happened. The Queen might well have turned to the Wizards, who themselves had been discussing this problem and recommended remedies for many years. But instead, she summoned a noted sorcerer from a far away land, Ira of the Unruly Hair. And Ira gathered a legion of fellow sorcerers, and convened them in a secret Star Chamber, a place so dank and dark no light could enter or escape.

They labored while the spring blossoms scented the trees. And they labored while the sun ripened the fruit on those trees. And they labored while the leaves on those trees began to fall to the earth. Then, one day the Queen sent a crier throughout the Kingdom to announce that Ira of the Unruly Hair had indeed produced a mighty plan and it would be wondrous to behold.

Report of the President of the AMA

Then they gathered every beast of burden in the Kingdom, all the oxen and horses and mules, and they hitched them to the machine on which they had placed the great plan — for the plan was not only great in inspiration but great in size — and they hauled it to the big, white castle and presented it to King Will. And King Will, who was chewing on the drumstick of a great wonk, placed his seal upon the plan.

Now, on a hill looking down on the white castle was a great hallowed hall with a round dome. And in that hall were knights of renown from every other castle in the Kingdom. They were divided roughly into two camps, and the shields of one camp bore the sign of the donkey, and the shields of the other the sign of the elephant. It was these knights' job to decide the laws of the land, but in truth, most of their days were spent in their favorite sport, which was jousting.

The leader of the donkeys, Sir George of the Land of Lobster, was one of the most feared jousters. He said: "Let them bring us the plan of King Will, so we can make it the law of the land."

And the oxen and horses and mules began to haul the mighty plan from the white castle to the hall on the hill. But a hue and cry went up throughout the hall almost as great as during the debate over where the knights could tie up their horses.

And the leader of the elephants, Sir Bobdole of the Land of Corn, who was famous for his skill with the lance, spoke: "Not so fast," said Sir Bobdole. "That plan has more fat than a roasted boar."

For it so happened that the donkeys and the elephants had opposing views on the health care of the people. The donkeys believed that the King and the knights should design the system, and decide what kind of training should be given to the Wizards and which Wizards the people could see. And the donkeys believed if the subjects would pay their tithe to them — they could fix the system.

But the elephants said the people were tithed too much and the money was wasted on things like midnight falconry. And they said the King and the great hall should stay out of it. And they accused the donkeys of being beholden to a knight of yore, Sir Franklin of the New Deal.

So the knights of the donkeys and the knights of the elephants devised their own plans: Sir George of the Land of Lobster, Sir Chafee of Rhodes, Sir Stark of Fortney, Sir Teddy of Camelot and others. But the champion of one plan, Sir Rosty of the Windy City, was injured when he was out delivering a gift to a subject and fell into a moat.

But these plans, too — five in all — were also placed on great machines and hauled out to be viewed by the people. And the knights returned to their jousting.

And now thick fog hid the sun, and thunder rent the air, and torrents of rain turned the land into mud, and the plans of King Will and all the plans of the great Hall got bogged down.

All the while the Wizards offered advice and counsel on the health of the people. And the people heard them and gave the Wizards their confidence. But the King and Queen and many in the Great Hall gave the people only the cold shoulder and the deaf ear.

Now there arose in the land a new evil that further threatened the health care of the people. One day, five great dragons from the Kingdom of Insurers appeared in the sky and encamped in every corner of the Kingdom. And on their wide wings were

markings sinister and strange. One had what looked like the giant rock of Gibraltar. Another had what looked like a great umbrella of crimson. Still a third was marked with a small cartoon beagle. People began to call them the Big Five, and they breathed fire, and made a bellowing that was terrible to hear, and were in general unmannerly. And they began making forays across the land, swooping down upon unsuspecting subjects and herding them into their own regions.

They swallowed up entire villages. And they plucked up select Wizards, and demanded that they tend only to the citizens they had corralled, and none other. And the citizens raised up a cry because they could no longer see the Wizards who had so carefully watched over them.

But as the dragons' plunder continued, their appetites, rather than be sated, grew only more ravenous. It was rumored that some dragons even tried to eat some of the others. And clouds darkened the sky and a great indigestion struck the bowels of the people, and they were sore afraid.

Ladies and gentlemen, most fairy tales end with everyone living happily ever after. And for that to happen here, you might expect that a white knight would appear to slay the dragons and knock some sense into the King, the Queen and the knights of the hall on the hill.

But the ending to this story has yet to be written.

The great plans of the King and Queen and all the knights of the Hall got bogged down under their own weight. The wheels came off the machines, and all the King's horses and all the King's men . . . well, you're already familiar with that verse.

And as a result, many knights lost their shields and left the great hall forever — although most went on to join the newly-formed Guild of Lobbyists. Some who remained were hoping to fix the Kingdom's health system by mixing up a special magic potion. Its main ingredient was Eye of Newt. Most of the knights, however, just went back to their jousting.

As for King Will and his Queen, the whole experience was enough to make them wish they were back in their forest, in their house surrounded by rushing white water.

The King has recently taken to traveling to foreign lands. But he never misses a chance to remind the Queen that you just can't trust a sorcerer.

What remains are the Wizards and the people — the true heart and soul of any health care system.

The people will continue to receive the best care on earth when they demand nothing less. We wizards must never forget that we can deliver that care only if we're united in our vision, our voice and our leadership. And, I believe we can write a fairy tale ending if we never forget that the true power of our magic is not what's under our hats, but what's in our hearts.

And for allowing me the privilege to be your chief wizard for a year — I thank you very much.

Physicians in Annapolis

Angelo J. Troisi, F.A.C.H.E.

Mr. Troisi is chief executive officer of the Medical and Chirurgical Faculty of Maryland.

EACH YEAR AN ISSUE OF THE *MARYLAND MEDICAL JOURNAL* IS DEDICATED TO INFORMING physicians about important legislative issues in Annapolis. This issue also contains the Maryland legislative directory and information on how to contact senators and delegates in your district or on specific committees. Important legislative dates are provided, as well as information on the legislative process itself.

Throughout the legislative session, Med Chi will continue to provide representation in Annapolis and will strive to make the health care system in Maryland the best it can be. To provide our members with up-to-the-minute information regarding events in Annapolis, Med Chi will use several methods. In our Annapolis office, we have installed WinFax Pro, a communications software package that allows staff to send a fax simultaneously to several groups of people. With this new system, faxes will be sent to specific groups including component society presidents and executives, members of the Med Chi Legislative Committee, chairpersons of the component society legislative committees, and physicians who have demonstrated an interest in specific legislative issues.

Legislative Action, a weekly newsletter published during the session, includes a synopsis of each bill being considered, the legislative committee's action on each bill, and a calendar of upcoming hearings. Members also can obtain legislative information on Med Chi's 24-hour automated hotline (1-800-209-9126).

In order to provide you with the best representation in Annapolis, we need your help. We need you, our members, to communicate with us about how you want to be represented. Keep us apprised of your views by contacting Med Chi staff and communicating with Med Chi leadership. If you have specific questions or concerns about a legislative matter, please call our Annapolis office at 410-263-4035, or call our Baltimore office at 410-539-0872 or 1-800-492-1056. We understand that caring for your patients is first and foremost on your agenda, but unfortunately in today's health system climate, becoming involved politically is necessary to keep control of the care you give.

Med Chi Annapolis office:
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Annapolis, MD 21401
410-263-4035

Speak Out

Death of the doctor-patient relationship: health system legislation and marketplace forces

The classic image of *The Doctor* as painted by Sir Lukes Fildes is indeed history. What happened?

During World War II, when the war economy required wage and price controls, the concept of fringe benefits was introduced to reward full employment and high productivity. And one of the first fringe benefits to be offered was "cradle-to-grave" health care provided by employers. It was also during World War II that, instead of merely providing comfort and support to the bereaved, as depicted by Sir Lukes, physicians began to save lives with innovative surgical and medical technology. We developed the best health care system in the world, largely because we were willing to pay heavily for it. The relentless increases in cost, however, should be understood as a result of the success of modern medicine and not its failure. People will pay anything to defend against the possibility of death, all the more so when the money involved does not come directly out of their own pockets.

In the absence of legislative and regulatory activity, health care responds to marketplace forces. There has been an explosion of entrepreneurial efforts led by insurance companies and independent managed care organizations that have seized an opportunity for large profits in the health care industry. With the emergence of health maintenance organizations (HMOs), physician provider organizations (PPOs), and physician hospital organizations (PHOs), more health care dollars are being diverted into administrative profit and "stockholder benefits."

The frenetic political process that characterized last year's federal effort to address health system reform was more appropriate to the selection of a pope. The collapse of that effort, however, was unfortunate, because in the process we lost the opportunity for public debate of issues such as who lives and who dies, suffering vs. survival, care for the terminal child, dialysis for patients in vegetative states, how many organ transplants are appropriate in a given individual, how much artificial life prolongation is appropriate and—more importantly—how much can we afford? In fact, societal issues have been laid aside: high infant mortality, crack babies, babies having babies, violence, and lifestyles that include substance abuse are put on the back burner because it is

Speak Out

easier for politicians and regulators to address delivery systems, health packages, and third-party payment.

Although the federal government struggled to a conclusion of inaction last year, the Maryland legislature passed a bill that included a significant portion of President Clinton's original proposals. Before the state law was enacted and the Health Care Access and Cost Commission was created, hospital regulation by the Health Services Cost Review Commission projected Maryland as an unattractive state for concepts of managed care. The recent state law, however, has made Maryland extremely attractive. We now have the third highest penetration of managed care, and in fact we are number one in the growth of managed care in the country. There appears to be a strange parallel tracking in health care in Maryland, however. At the same time that market forces are responding to the demand from purchasers of health care for better cost containment, our state legislative and regulative process is turning more of its attention, through the use



of task forces, to the same issue. Access is being addressed to some extent, but it appears to be of limited interest.

As a result of all the changes that have been occurring in health care delivery, many doctors find themselves trying to learn about alternative modes of practice and new concepts of compensation. New practice patterns, compensation systems, corporate mergers, and specialty mixes are affecting physicians' lifestyle and career decisions. With typical managed care penetration, a wide spectrum of physicians now devote a major portion—if not most—of their time to the service of such organizations. Physician relationships have been strained and friendly competition has become more serious. And, for the first time in the history of American medicine, physician livelihoods are seriously threatened; thousands of doctors in the United States and an increasing number of physicians in Maryland find themselves unable to make a living. After a short period of time, economic credentialing has been devastating to physicians who, having sacrificed to accommodate managed care, find themselves with a large percentage of their practices simply cancelled to support a new financial nightmare: profiteering at the expense of the sick.

It is likely that there will be progressive, market-driven changes in physician services in Maryland like those considered successful by *buyers* of health care in other states. Physician services will integrate through four stages. First, doctors will forsake solo practice and, through horizontal integration, will share space and then participate in independent practice associations (IPAs) and PPOs. Second, doctors will enter a group to share revenue and expenses, such as group practices without walls, or single specialty groups. These first two stages of horizontal mergers are highly vulnerable. Third, mergers with primary care physicians can be anticipated by multi-specialty group practices that may become progressively larger. Even this phase, however, has only a fair chance for continued survival. In the final stage, vertical integration will likely evolve, with group practices taking full capitation and security provided in a full health system process involving physician groups, specialists, hospitals, and home care.

In all of this activity, the doctor-patient relationship appears to be irrelevant. Patients receive fewer choices in selecting a personal physician. Although they demand quality, it is somehow missing from the formula. Yet, under the guise of quality, managed care organizations are dictating medical practice. Permission to perform procedures, to test, or even to see patients, is being governed to assure that appropriate profit is achieved. The art of medicine is no longer a topic of discussion.

The anxiety provoked by this environment is felt by physicians and patients alike. We are only beginning to hear from our patients about their dissatisfaction with rationed care. As physicians, we must be our patients' advocates. We must support patient access legislation, which is being vigorously attacked by managed care and by industry. Patient access legislation is basically a "truth in

Speak Out

advertising" effort. Patients must be advised what their managed care contracts do and do not cover. The quality assurance and utilization review process must be more open and there must be a more patient-friendly appeals process for both patients and physicians.

We hope that our regulators and legislators will address the improprieties of the huge for-profit health care industry that is consuming vast sums that need to be devoted to patient care and research. Emphasis in our legislative and regulative arena should be the protection of patients and physicians. Most important is insurance reform dealing with such injustices as pre-existing conditions and portability of benefits. Every health care system should provide a point-of-service option with no cost other than a copayment by patients who exercise such freedom of choice. The imposition of practice parameters, payment schemes, and tabloid data acquisition is threatening to doctors and certainly far less appropriate than managed care quality assessment, which may very well be abandoned by our Health Care Access and Cost Commission for lack of funds. We also need further tort reform.

Young people, healthy patients, and young, healthy families are all cost conscious and have embraced impersonal health care. Those with long-standing disease, however, have insisted on the right to choose their own doctors. The gloomy reality is that our population is getting older; by the year 2010, 20% of the population will be over age 65. This demographic trend will increase the demand for medical services.

As various states introduce health care system concepts, we will need to watch the possible migration of physicians who will go where they feel they can best represent the needs of their patients and at the same time effectively provide for their own families.

DONALD H. DEMBO, M.D.
Dr. Dembo is president of the Medical and Chirurgical Faculty of Maryland. ■

Share your opinions

The Editorial Board of the *Maryland Medical Journal* encourages Med Chi members to share their opinions, beliefs, and convictions about all aspects of medicine. Letters to the Editor and essays for *Speak Out* should be sent to Editor, *Maryland Medical Journal,* 1211 Cathedral Street, Baltimore, MD 21201-5585.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

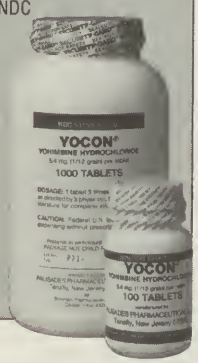
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



References:

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2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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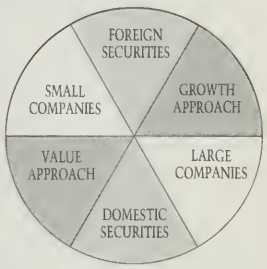
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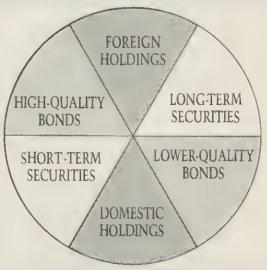


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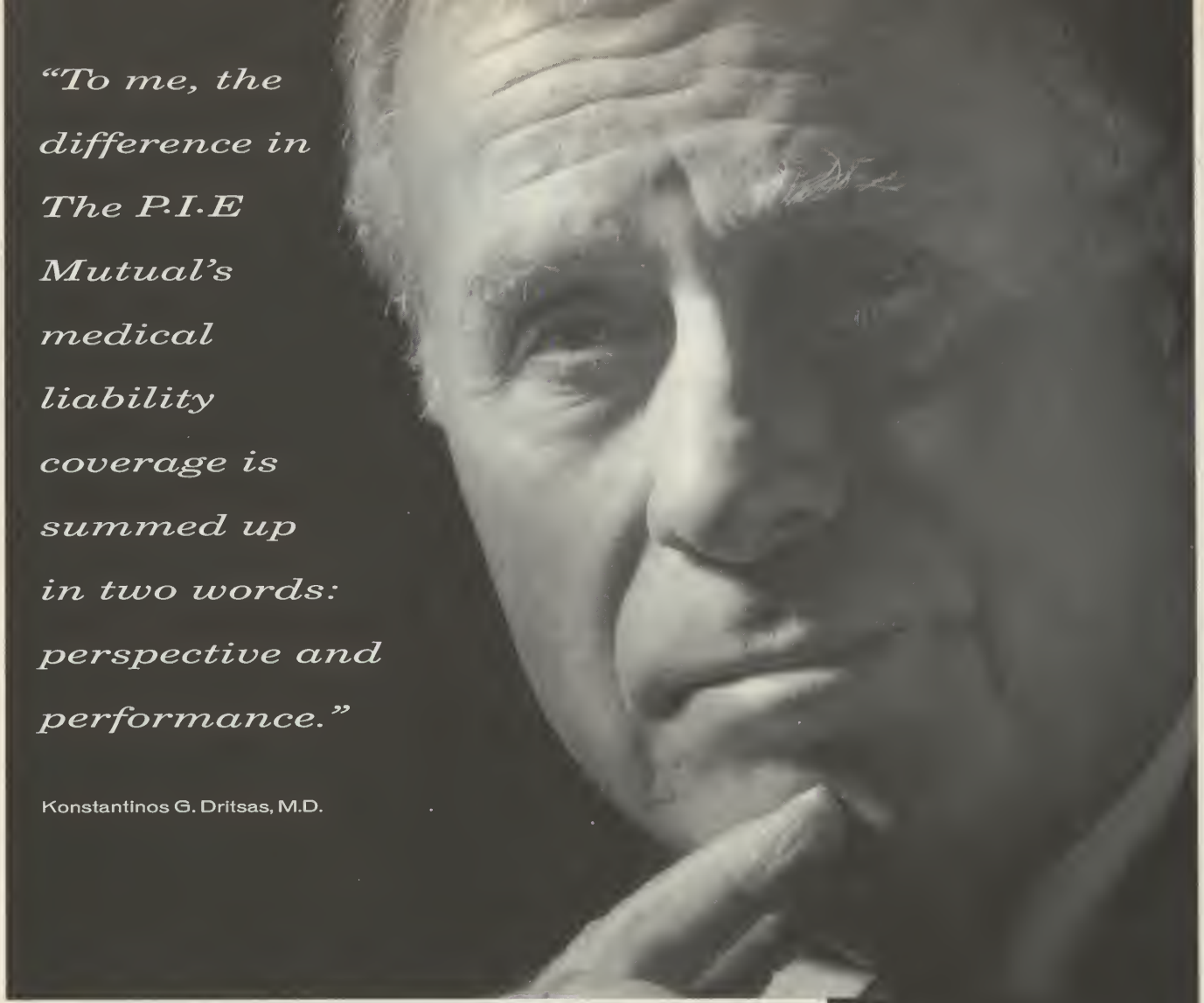


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Smoking behavior, workplace policies, and public opinion regarding smoking restrictions in Maryland

Donald R. Shopland, Anne M. Hartman, James L. Repace, and William R. Lynn

ABSTRACT: *The Maryland Occupational Safety and Health (MOSH) advisory board recently proposed a smoking ban in most Maryland workplaces, including bars and restaurants, unless smoking is restricted to a separately ventilated area where nonsmoking workers cannot be required to enter. Results from the 1992-1993 Current Population Survey strongly suggest that there is broad support among Maryland residents for such restrictions and that the MOSH rules would merely extend an already widespread practice in the state. Efforts by the tobacco industry to gain an injunction against the proposed MOSH regulations would not appear to be supported by a clear majority of Maryland residents.*

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During the past two decades, the scientific evidence establishing environmental tobacco smoke (ETS) as a significant health risk in non-smokers has increased considerably. Hundreds of studies in the worldwide scientific literature and a number of major independent reviews[1-6] indicate that ETS is a significant cause of lung cancer in adults and other serious respiratory diseases in both adults and children. Recent evidence also strongly suggests a causal association between ETS and coronary heart disease and sudden infant death syndrome.[7,8]

There has been an increasing demand that public accommodations be free of tobacco smoke.[9-11] As a result of action taken by individuals and legislative and regulatory initiatives at the national, state, and local levels,[13,14] smoking is restricted or entirely banned in many work sites, restaurants, schools, transportation facilities, shopping malls, hospitals, and sports complexes.[12]

The Maryland Occupational Safety and Health (MOSH) advisory board recently proposed a complete smoking ban in most Maryland work sites,

including restaurants and bars, to protect Maryland workers from the documented health risks associated with ETS exposure.[15] As a result of a successful legal challenge backed by the tobacco industry, however, implementation of the proposed smoking ban is now in doubt.[16]

This article presents results from the Current Population Survey (CPS) Tobacco Use Supplement conducted for the National Cancer Institute (NCI) by the U.S. Census Bureau between September 1992 and May 1993. Included are data on smoking prevalence in Maryland and how it compares to other states in the South Atlantic region; the percentage of the Maryland workforce that is currently covered by workplace smoking policies and the characteristics of those policies; and public opinion in Maryland regarding smoking restrictions in work sites and other public places.

Methods

The CPS is a continuous monthly survey conducted by the U.S. Census Bureau that focuses primarily on labor force indicators for the civilian, noninstitutionalized U.S. population aged 15 and older.[17] Approximately 56,000 eligible households (representing approximately 110,000 people; 55% self-respondents and 45% by proxy) are surveyed each month.[18]

In 1991, the NCI funded an interagency agreement with the Census Bureau to add a tobacco use supplement to the CPS. Questions on smoking and tobacco use were added to the September 1992, January 1993, and May 1993 surveys. To minimize the number of proxy responses, the supplement questionnaire was printed on a form separate from the standard core questionnaire, so that data collection was not constrained by the one-week limit for labor statistics collection. Approximately 25% of all interviews were conducted in person and 75% by telephone. (The 1992-93 CPS Tobacco Use Supplement is available as a public use data tape from the U.S. Census Bureau.)

Data analysis in the current study is limited to individuals 20 years of age and older at the time of interview. Separate information on demographic subgroups other than whites and blacks is not presented due to the small number of interviews involved. Smoking prevalence estimates cited in Table 1 are based on proxy and self-reported responses; information on cigarette use obtained from proxies generally has been shown to be in very close agreement with that obtained through self-reports.[18,19] All other estimates (Tables 2 and 3) are based on self-responses. All data are weighted for nonresponse according to an algorithm developed for the tobacco use supplement by the Census Bureau; in cases in which estimates are based on self-only responses, all weighted estimates reflect self-only response weights. Prevalence data for Maryland presented below are limited to adults (N = 2553) and are based on both self and proxy responses.

Questionnaire structure

The CPS tobacco use questionnaire is a major part of a larger series of assessments designed to evaluate a 17-state, comprehensive smoking control project funded by the NCI.[20] It was developed by NCI staff and pre-tested by trained Census Bureau interviewers prior to full field implementation. Questions measuring smoking status are consistent with those recently adopted by the National Center for Health Statistics for use in other federal health studies such as the National Health Interview Survey.[21]

Respondents were asked if they ever smoked 100 cigarettes (5 packs) in their lifetime. Those who answered *no* were considered never-smokers. Those who answered *yes* were asked if they smoke cigarettes every day, some days, or not at all. Those who answered *every day* or *some days* were considered current smokers; those who answered *not at all* were classified as former smokers. Respondents who answered *don't know* to the first question or who did not answer the next two questions were excluded.

The questionnaire also sought information about official workplace smoking policies among adult workers in Maryland who were currently employed, worked outside their home, did not work outdoors or in a motor vehicle, did not travel to different buildings or sites, and were not self-employed (N = 1018). Eligible respondents were asked if their place of work had an

Table 1. Prevalence of cigarette smoking* among adults in Maryland, the United States, and South Atlantic Division states. Current Population Survey, 1992-93.

	Men	Women	Total
United States	26.8	21.8	24.1
Maryland	**24.6**	**23.5**	**24.0**
Delaware	24.1	22.8	23.4
Washington, DC	26.3	21.1	23.5
Virginia	29.9	22.0	25.7
West Virginia	33.0	28.2	30.5
North Carolina	31.8	22.8	27.0
South Carolina	29.8	22.8	26.0
Georgia	28.7	21.2	24.7
Florida	27.0	21.6	24.1

** Includes those who smoke every day and some days.*
Total number of interviews in all states in South Atlantic Division: 44,434

Table 2. Prevalence and characteristics of work site smoking policies in Maryland. Current Population Survey, 1992-93

	Total percent of employees covered by existing policy	Degree of Workplace Smoking Restriction			
		NO smoking permitted in either public areas or work areas	Smoking is permitted in SOME public areas but NO work areas	Smoking is permitted in SOME public and SOME work areas	NO smoking permitted in any public area but allowed in SOME work area
All workers (N=1018)	83.2	51.6	18.4	7.1	2.8
Men (N=394)	82.7	47.1	19.2	7.9	2.4
Women (N=624)	83.5	54.6	17.9	6.4	3.1
White (N=717)	83.1	53.5	16.9	6.9	3.0
Black (N=237)	84.7	49.0	22.1	7.2	1.9

N = number of interviews.
All data based on self-only reports.

official policy that restricted smoking in any way. Those who answered yes were asked, Which of the following best describes your place of work's smoking policy for indoor public or common areas such as lobbies, rest rooms, and lunch rooms? and, Which of the following best describes your place of work's smoking policy for work areas? Response categories for both questions were: not allowed in any areas, allowed in some areas, allowed in all areas, don't know, and not applicable.

Questions also were formulated to measure public attitudes and beliefs about smoking restrictions in various public settings (restaurants, hospitals, indoor work areas, bars and cocktail lounges, indoor sporting events, and indoor shopping malls). All adult, self-only respondents with known smoking status, regardless of employment status (N = 2,134), were asked if smoking should be allowed in all the named public areas, in some areas, or not allowed at all.

Results

Response rates to the CPS core questionnaire were 95.7%, 95.3%, and 95.2% for September 1992, January 1993, and May 1993, respectively. Response rates for the tobacco use questionnaire were 88.5% (September), 89.1% (January), and 86.1% (May); 18% were proxy responses.

Smoking prevalence in Maryland. Fewer than 1 in 4 adults in Maryland were classified as current smokers, nearly identical to the proportion of adult smokers in the overall U.S. population. Almost as many women as men were smokers in Maryland, a finding somewhat different from national data. The overall smoking prevalence rate for Maryland was similar to that in many South Atlantic Division states, although in several states the rates were noticeably higher (see **Table 1**).

Workplace smoking policies in Maryland. A small majority of eligible adult workers (51.6%) reported that their employer's policy did not permit smoking in the work area or the common and public areas of their work site. Approximately 1 in 5 employees reported that smoking was allowed in some common or public areas in the work site, but not in the work area itself. The percentage of Maryland employees covered by policies with other characteristics was exceedingly small (generally less than 1%; the total of all other categories combined was less than 4%). Thus, the data in **Table 2** are limited to the four most frequently reported workplace policy combinations.

Table 3. Attitudes and support for smoking restrictions expressed by Maryland residents, according to setting (place), gender, race/ethnicity, and smoking status. Current Population Survey 1992-93

	ALL (N=2134)	SMOKER (N=513)	NON-SMOKER (N=1621)	MEN (N=899)	WOMEN (N=1235)	WHITE (N=1525)	BLACK (N=502)
Indoor Work Areas							
Not allowed at all	59.3	30.9	68.3	56.5	61.5	57.0	62.4
Allowed in some areas	37.7	61.9	30.0	38.5	37.1	40.2	34.6
Allowed in all areas	2.2	5.3	1.2	3.8	1.0	2.3	2.0
Restaurants							
Not allowed at all	46.9	17.3	56.3	46.4	47.2	44.9	50.1
Allowed in some areas	49.5	74.0	41.7	48.6	50.2	52.2	44.5
Allowed in all areas	3.0	8.0	1.5	4.1	2.2	2.8	3.6
Bars and Cocktail Lounges							
Not allowed at all	26.1	4.3	33.1	26.3	26.1	23.9	29.6
Allowed in some areas	45.9	46.3	45.8	43.5	47.7	47.9	42.1
Allowed in all areas	26.7	47.8	20.0	29.2	24.8	27.1	26.7
Indoor Shopping Malls							
Not allowed at all	52.1	28.2	59.7	49.7	54.0	49.3	57.3
Allowed in some areas	41.7	59.7	36.0	41.6	41.7	44.6	36.6
Allowed in all areas	5.8	11.1	4.1	8.1	4.0	5.8	5.5
Indoor Sporting Events							
Not allowed at all	64.0	44.2	70.2	61.9	65.5	60.8	70.7
Allowed in some areas	30.3	44.6	25.8	30.1	30.5	33.3	24.3
Allowed in all areas	5.0	10.0	3.4	7.4	3.2	5.3	4.4
Hospitals							
Not allowed at all	77.9	62.4	82.8	77.8	78.0	75.8	82.0
Allowed in some areas	20.8	34.4	16.4	20.0	21.3	23.1	15.9
Allowed in all areas	0.8	2.2	0.4	1.5	0.3	0.9	0.7

All data based on self-reports only.

Attitudes toward smoking restrictions.

Table 3 shows Marylanders' opinions about smoking restrictions in various public settings.

Indoor work sites. By a wide margin, Marylanders favored a complete ban on smoking in indoor work areas. Slightly more than one third would allow smoking in some work areas, but only 2% would allow it in all indoor work areas. Women and blacks were somewhat more likely than men and whites to say that smoking should not be permitted in indoor work areas. Nearly 7 out of 10 nonsmokers said smoking should not be allowed at all; 3 out of 10 said it should be allowed in some areas. Almost one third of smokers favored a complete workplace smoking ban, although the majority said smoking should be allowed in some areas. Among smokers, more blacks (41.1%) than whites (26.2%) favored a complete workplace smoking ban.

Restaurants. Respondents were almost equally divided between banning smoking in restaurants and allowing it in some areas. A clear majority of nonsmokers (56%) and 1 in 6 smokers (17.3%) favored a complete ban.

Bars and cocktail lounges. As many Marylanders would ban smoking in bars and cocktail lounges as would permit it in all areas; nonsmokers outnumbered smokers in favoring a complete ban, but 20% of nonsmokers would allow it in all areas. Overall, 46% of Marylanders (an equal percentage of smokers and nonsmokers) would restrict smoking to some area within these establishments. Almost as many smokers

favored restricting smoking to some areas as favored permitting it in all areas.

Indoor shopping malls. A majority of Marylanders (6 out of 10 nonsmokers and nearly 3 out of 10 smokers) favored a smoking ban in shopping malls. Four of 10 would allow smoking in some areas. Blacks (including 40% of smokers) were much more likely than whites to favor smoke-free indoor malls.

Indoor sporting events. An overwhelming majority of Maryland residents (7 out of 10 nonsmokers) said smoking should not be allowed at indoor sporting events. Only 1 in 4 nonsmokers would permit smoking in some areas. Among smokers, approximately the same number of smokers would allow smoking in some areas as would ban it completely. Only 5% of all adults and only 10% of all smokers would allow it in all areas.

Hospitals. A clear majority of respondents (80% of all adult respondents; 62% of smokers) agreed that smoking should not be allowed in hospitals.

Discussion

Impact on business. The proportion of the adult Maryland population that smokes has decreased 20% since 1985.[9,22] As both the proportion and absolute number of nonsmokers increase, the demand for smoke-free public accommodations will also increase. The major cigarette manufacturers have vigorously opposed the MOSH advisory board's proposed smoking ban, which would affect many work sites not previously covered by regulations or ordinances (e.g., bars and restaurants). One of the tobacco industry's major arguments is that the state failed to assess sufficiently the economic impact such a wide-reaching regulation would have on businesses.[23] Proprietors of restaurants and bars also have expressed concern that such regulations will place them at a competitive disadvantage with establishments in surrounding jurisdictions. Smokers, they contend, will choose not to patronize establishments that do not accommodate their behavior.

These concerns, however, may be unfounded. Glantz and Smith[24] compared restaurant sales revenues from 1986 through 1993 in 15 cities with smoke-free ordinances to revenues in 15 similar communities without smoke-free ordinances. They found that ordinances had no statistically significant effect on sales. Two examples are particularly noteworthy. Following the passage of a smoke-free ordinance in Beverly Hills in 1987, the tobacco industry succeeded in having it repealed four months later on the grounds that it was responsible for a 30% reduction in restaurant sales. Glantz and Smith found no such decline during the period the ordinance was in effect and no increase in sales following its repeal. In another California city where a smoke-free ordinance was repealed because of claims that business declined, the ordinance in fact was associated with a marginally significant ($P = .025$) increase in business.

Impact on smokers. Smokers' advocacy groups have argued that smokers cannot forego cigarettes at work for prolonged periods because they need cigarettes to cope with every-day workplace tensions. Experience in other areas, however, suggests otherwise. For example, the airline smoking ban (enacted in 1990) eliminated smoking aboard all commercial aircraft for flights lasting six hours or less. Since major airport facilities across the country are now smoke-free, smokers on long and/or interconnecting flights may be unable to smoke for seven to eight hours, yet the Department of Transportation has reported almost no problems with compliance. Businesses that have banned smoking, in some cases for many years, also report no problems with compliance or smoker adaptation.[9,25,26]

Impact of environmental tobacco smoke. Although customers may spend up to a few hours per week in restaurants, bars, and cocktail lounges where smoking is permitted (either unrestricted or in smoking areas), employees in these settings may be subjected to a significant level of ETS. The proposed MOSH regulations were designed to protect employees (48% of the adult Maryland workforce) not currently covered by policies that eliminate smoking in both the work and public areas of a work site.

The tobacco industry has argued that the state has not sufficiently demonstrated that ETS poses a significant health risk to workers. However, it is estimated that in Maryland, 1500 deaths per year are due to heart disease and lung cancer attributable to ETS and that 50% or more of these deaths are due to workplace ETS exposure.[27,28] British investigators[29] have estimated that living or working in asbestos-containing buildings is associated with an annual risk of lung cancer less than 1 in 1,000,000, a rate deemed unacceptable as evidenced by the efforts made to remove asbestos from work sites, schools, and other public buildings. The same investigators state that the relative risk for lung cancer due to ETS "is more than 100 times higher than the estimated effects of 20 years' exposure to the amount of chrysotile asbestos normally found in asbestos containing buildings."[30]

Conclusion

Allowing the tobacco industry to delay action designed to reduce a significant but entirely preventable health risk among workers could result in hundreds of unnecessary deaths annually in Maryland. The proposed MOSH regulations are justified on the basis of a significant public health risk, practical in terms of their likely acceptance by smokers, and likely to have little or no economic impact on Maryland employers.

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Investigators who conducted a population-based study of people born in central Sweden between 1945 and 1954 have reported a significantly increased risk of Crohn's disease among those born during or just after a measles epidemic (Ekbom A, Wakefield AJ, Zack M, Adami HO. Perinatal measles infection and subsequent Crohn's disease. *Lancet* 1994;344:508-510).

Competency assessment of medical and psychiatric patients under Maryland's Health Care Decisions Act

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ABSTRACT: *The Health Care Decisions Act provides considerable flexibility and autonomy for patients regarding advance directives and surrogate decision making and clarifies how patients can tell their physicians and the world in general what they would like to have happen if they become incapable of making their own health care decisions. The law, however, is complex. This article provides help for physicians in interpreting some of the Act's clinical and legal ramifications.*

The Health Care Decisions Act,[1] which became law in Maryland in October 1993, clarifies what physicians should do if, on the basis of clinical assessment, they judge a patient to be clinically incompetent. Under the Act, patients are considered incompetent if they are "incapable of making an informed decision about their own health care." Although technically *competency* is a legal term and only a judge can declare a patient legally incompetent, physicians frequently assess patients' capacity to make informed decisions about their health care. This capacity is often termed *clinical competency* or *medical capacity*. In the present discussion, the terms *competence* and *competency* are used to refer to clinical capacity as assessed by physicians, rather than to a legal status pronounced by a judge.

Assessing competency

All adult patients are presumed competent to make medical treatment decisions for themselves. Many patients who initially disagree with their physician's advice have appropriate concerns about the proposed treatment. Time spent by the physician with the patient and family often results in agreement among the parties about what is best. Questions about competence usually arise in the clinical setting when the patient, physician, and family cannot agree on the best course of action. In this situation, the

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physician's first responsibility is to clarify the nature of the problem, for it may not be one of competency at all.

In the process of clarification, the physician should think clinically before thinking legally. Clinical thinking often reveals that what appears to be a problem in competency is actually a problem in communication (e.g., the patient or family does not understand the proposed treatment; the physician does not understand the patient's fears) or a problem in relationships (e.g., the physician has slighted the patient, whose response is to frustrate the physician's efforts; a disagreement between the patient and family has more to do with preexisting quarrels than with the patient's current medical situation). In most cases, members of the treatment team are able to recognize and address such issues; if resolution of the problem proves difficult, a consultation from the psychiatry service may be helpful.

Even when it is clear that the patient's competence to make medical decisions is impaired, physicians should still think clinically before thinking legally. This is important because the first question to be answered in the assessment of competence is, Competent to do what? The patient may well have the capacity to understand and decide about a straightforward, safe, minor treatment, but not a complex, risky, major one. Judgments about competence are therefore made in a context that includes not only the patient's mental state, but also the nature of the decision to be made.

Once the assessment of competence is undertaken, a thorough history and examination of the patient's mental state are required. The goal is to document phenomena (e.g., coma, delusions, hallucinations, dementia) that might affect the patient's capacity to make the decision in question. A quantitative test of cognitive functioning (e.g., the Mini-Mental State Examination[2]) should be part of the evaluation. Assessment of whether the patient has a factual understanding of the proposed treatment, including its benefits, risks, and alternatives, is also important. If the clinical judgment is that the patient truly lacks the capacity to make informed health care decisions, the physician has four choices.

Options in the absence of competence

Guardian or health care agent. First, if the patient has a previously appointed guardian or health care agent under an advance directive, the physician should read the guardianship or advance directive document to see if it allows the guardian or health care agent to consent in place of the incompetent patient. Consultation with an attorney is useful when the document is ambiguous.

Wait until competency returns. Second, if the patient does not have a guardian or health care agent, the physician could choose to take no action until the patient returns to competency. This approach is indicated when the proposed treatment is not urgent and the patient is suffering from a disorder (e.g., intoxication, delirium) that is expected to resolve.

Intervention without informed consent. Third, in certain circumstances, the physician can intervene without informed consent. The Health Care Decisions Act authorizes treatment without consent in a medical emergency if the attending physician determines that "there is a substantial risk of death or immediate serious harm to the patient and, within a reasonable degree of medical certainty, the life or health of the patient would be affected adversely by delaying treatment to obtain consent." This determination should be documented in the patient's chart using the language of the preceding sentence.

Surrogate. Finally, a surrogate can be appointed for a patient who is clinically judged incapable of making an informed decision. Before using a surrogate decision maker, the attending physician and a second physician, "one of whom shall have examined the patient within two hours of making certification, shall certify in writing that the patient is incapable of making an informed decision regarding the treatment." Although the two-hour limit applies to only one physician, the other also must have personally examined the patient.

Surrogate decision makers

The following individuals or groups, in order of priority, may make surrogate decisions for a patient:

- a guardian, if one has been appointed;
- the spouse;
- an adult child;
- a parent;
- an adult sibling; or
- another relative or friend who meets specific requirements (the Health Care Decisions Act requires that an affidavit be executed and in such circumstances, an attorney should be consulted).

Individuals in a particular surrogate class may be consulted only if all individuals in the next higher class are unavailable. Although surrogate decision making *cannot* be used for sterilization or treatment of a psychiatric disorder, it can be used if a psychiatric disorder causes the patient to be incapable of making an informed decision about the treatment of nonpsychiatric disorders. If surrogate decision makers disagree about the best course of action, or if the physician believes a surrogate is not acting responsibly, the case should be referred to either the legal office or the psychiatric consultation service for further help.

Guardianship is the traditional method for legally appointing a surrogate decision maker. When the above-noted surrogate process cannot be used (usually because no surrogate is available), guardianship is the only remaining option. The guardianship process requires a formal judicial hearing during which the patient has the right to be present, have counsel, present evidence, and cross-examine witnesses. A judge determines whether the patient meets the legal definition of incompetency and, therefore, whether a guardian should be appointed.

The guardianship process is complex and expensive, but it can be expedited. Most hospitals have policies and procedures for initiating a guardianship proceeding. A psychiatric consultation can be helpful in the clinical assessment of a patient for whom guardianship is being requested.

Psychiatric hospitalization

Admission of patients to a psychiatric hospital is even more complicated. For the past 30 years, psychiatrists have attempted to maximize voluntary admission to psychiatric hospitals and minimize involuntary admission, which in part has been accomplished by persuasion. In other cases, however, patients who may not have been fully capable of making an informed decision about voluntary admission and who gave no indication that they were unwilling to be a patient in the hospital were allowed to become voluntary patients. That is, psychiatrists have allowed patients to *assent* to be voluntary patients when they may not have been competent to give fully informed *consent* to hospitalization as voluntary patients.

A recent Supreme Court case now calls this practice into question.[3] David Burch, later diagnosed as paranoid schizophrenic, was found wandering along a Florida highway, bruised, bloody, and disoriented. He was taken to a community mental health center, where he was found to be hallucinated and confused; he thought he was "in heaven." He signed in voluntarily to a local hospital and three days later signed in voluntarily to a state hospital. No inquiry as to Burch's competence was made at either facility (Florida law requires that a voluntary patient must make application by "expressed and informed consent"). Burch remained hospitalized for five months without a review of his voluntary status. He later sued, claiming that he was not competent to sign in voluntarily to the hospital. His suit was dismissed at the trial court level. Burch appealed and his case was subsequently heard by the U.S. Supreme Court, which decided the case on a technical legal issue unrelated to the issue of voluntary psychiatric hospitalization. In its discussion, however, the court commented that the manner of Burch's confinement "clearly infringed on his liberty interests."

Like Florida, Maryland currently requires a voluntary patient to be competent. To be admitted voluntarily to a psychiatric hospital in Maryland, a patient must

- have a treatable mental disorder;
- understand the nature of the request for admission;
- be able to *give continuous assent to retention by the facility*; and
- be able to *ask for release* [emphasis added].[4]

Thus, it can be argued that to be voluntarily admitted to a psychiatric hospital in Maryland, a patient's competency to give informed consent for admission must be assessed.

The Health Care Decisions Act addresses part of this difficulty. In Maryland, advance directives can be either in formal written legal language or in oral form from a discussion with the treating physician that is subsequently documented in the patient's medical record. The advance directive can be broadly or narrowly drafted and can include authority to appoint a health care agent. The advance directive could give the health care agent the authority to admit the patient to a psychiatric hospital if the patient becomes incompetent at some point in the future.

The foregoing means, in effect, that unless a patient has an advance directive specifying that his or her health care agent can admit the patient voluntarily to a psychiatric hospital, a patient who is not competent to understand the voluntary admission process may not be voluntarily admitted to a psychiatric hospital. Guardians are forbidden by statute from signing a patient voluntarily into a psychiatric hospital.[5] Surrogate decision makers under the surrogate decision-making statute are also forbidden. Thus, without a previously written advance directive, there does not appear to be a method for providing psychiatric hospitalization for an incompetent, non-dangerous, non-objecting patient.

Until this situation is changed, psychiatrists can minimize future risk to their patients by encouraging them to formulate an advance directive. An oral advance directive can be fashioned from a discussion between patient and physician by indicating in the patient's medical record that

- at the time of the discussion, the patient was competent to make informed decisions regarding his or her health care;
- the patient wishes to be voluntarily admitted to the hospital if he or she becomes incompetent and requires psychiatric hospitalization; and
- the patient appoints a health care agent.

The physician should review these notations in the presence of the patient and one witness. The physician and the witness should then sign the medical record entry. If the patient subsequently seeks voluntary psychiatric admission and is not competent to do so, the health care agent could then sign the voluntary admission form.

Table 1 and **Figures 1-7** may help physicians appropriately apply this area of law. Several aspects of the Health Care Decisions Act, however, are open to interpretation (see annotations to the figures). Physicians who are unclear about legal (rather than clinical) aspects of the Act are advised to seek legal counsel.

Table 1. Admissions decisions for medical and psychiatric patients thought to be not clinically competent

	Voluntary psychiatric admissions	Medical treatment *without* risk of a substantial harm to life	Medical treatment *with* risk of a substantial harm to life	Psychiatric treatment (not voluntary admission) *without* risk of a substantial harm to life	Psychiatric treatment (not voluntary admission) *with* risk of substantial harm to life
Guardian of the person	no	maybe*	maybe,* with the court's authorization	maybe*	maybe,* with the court's authorization
Surrogate decision making	no	yes	yes	no	no
Durable power of attorney for health care executed prior to Health Care Decisions Act (10/1/93)	maybe*	maybe*	maybe*	maybe*	maybe*
Advance directive under the Health Care Decisions Act	maybe*	maybe*	maybe*	maybe*	maybe*

** Read document to see if it specifically allows the class of treatment being considered. If uncertain, obtain a legal consultation.*

Figure 1.

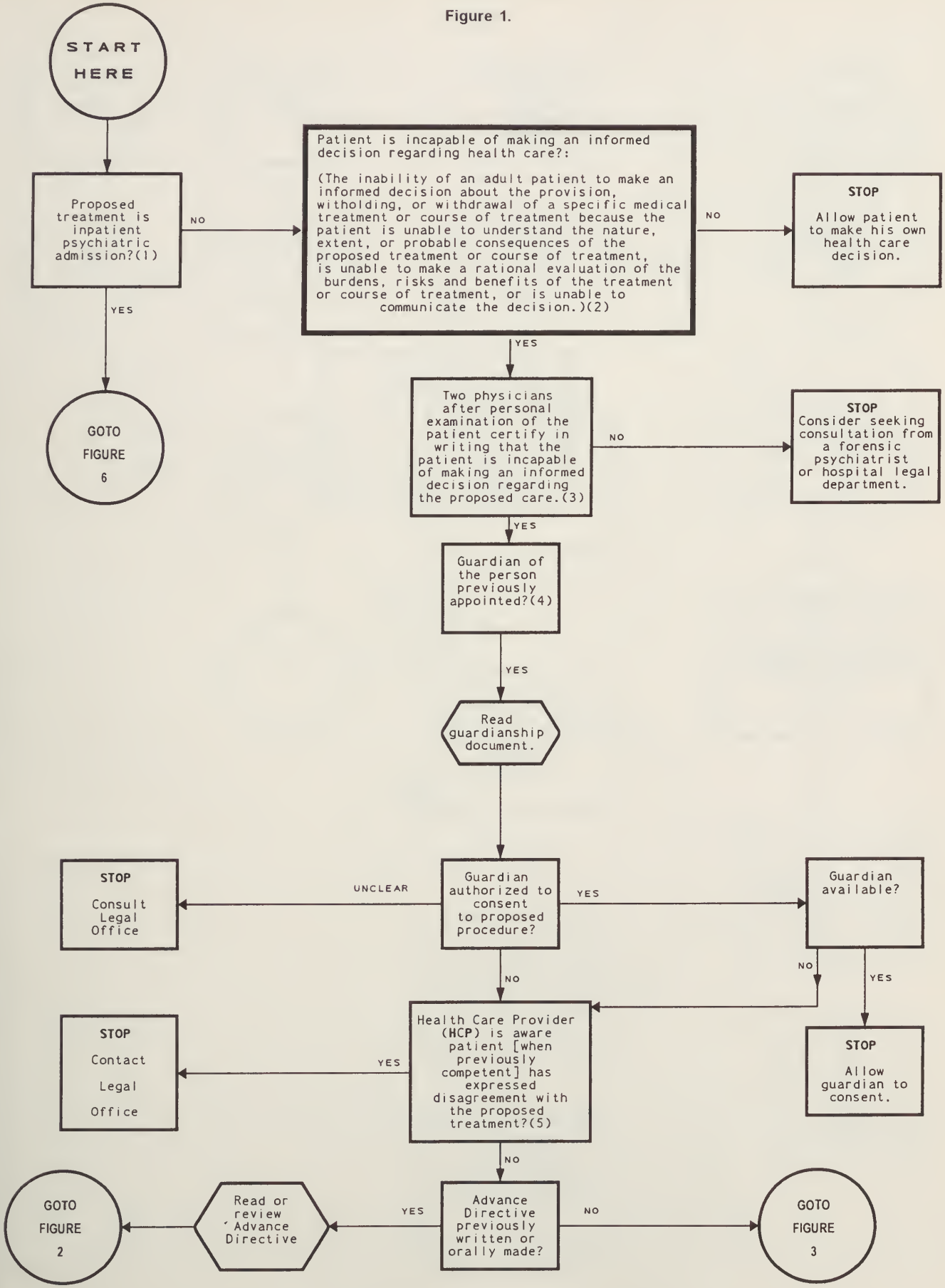

START HERE
Proposed treatment is inpatient psychiatric admission?(1)
NO
YES
GOTO FIGURE 6
Patient is incapable of making an informed decision regarding health care?:
(The inability of an adult patient to make an informed decision about the provision, witholding, or withdrawal of a specific medical treatment or course of treatment because the patient is unable to understand the nature, extent, or probable consequences of the proposed treatment or course of treatment, is unable to make a rational evaluation of the burdens, risks and benefits of the treatment or course of treatment, or is unable to communicate the decision.)(2)
NO
STOP
Allow patient to make his own health care decision.
YES
Two physicians after personal examination of the patient certify in writing that the patient is incapable of making an informed decision regarding the proposed care.(3)
NO
STOP
Consider seeking consultation from a forensic psychiatrist or hospital legal department.
YES
Guardian of the person previously appointed?(4)
YES
Read guardianship document.
Guardian authorized to consent to proposed procedure?
UNCLEAR
STOP
Consult Legal Office
YES
Guardian available?
NO
YES
STOP
Allow guardian to consent.
NO
Health Care Provider (HCP) is aware patient [when previously competent] has expressed disagreement with the proposed treatment?(5)
YES
STOP
Contact Legal Office
NO
Advance Directive previously written or orally made?
YES
Read or review Advance Directive
GOTO FIGURE 2
NO
GOTO FIGURE 3

Figure 2.

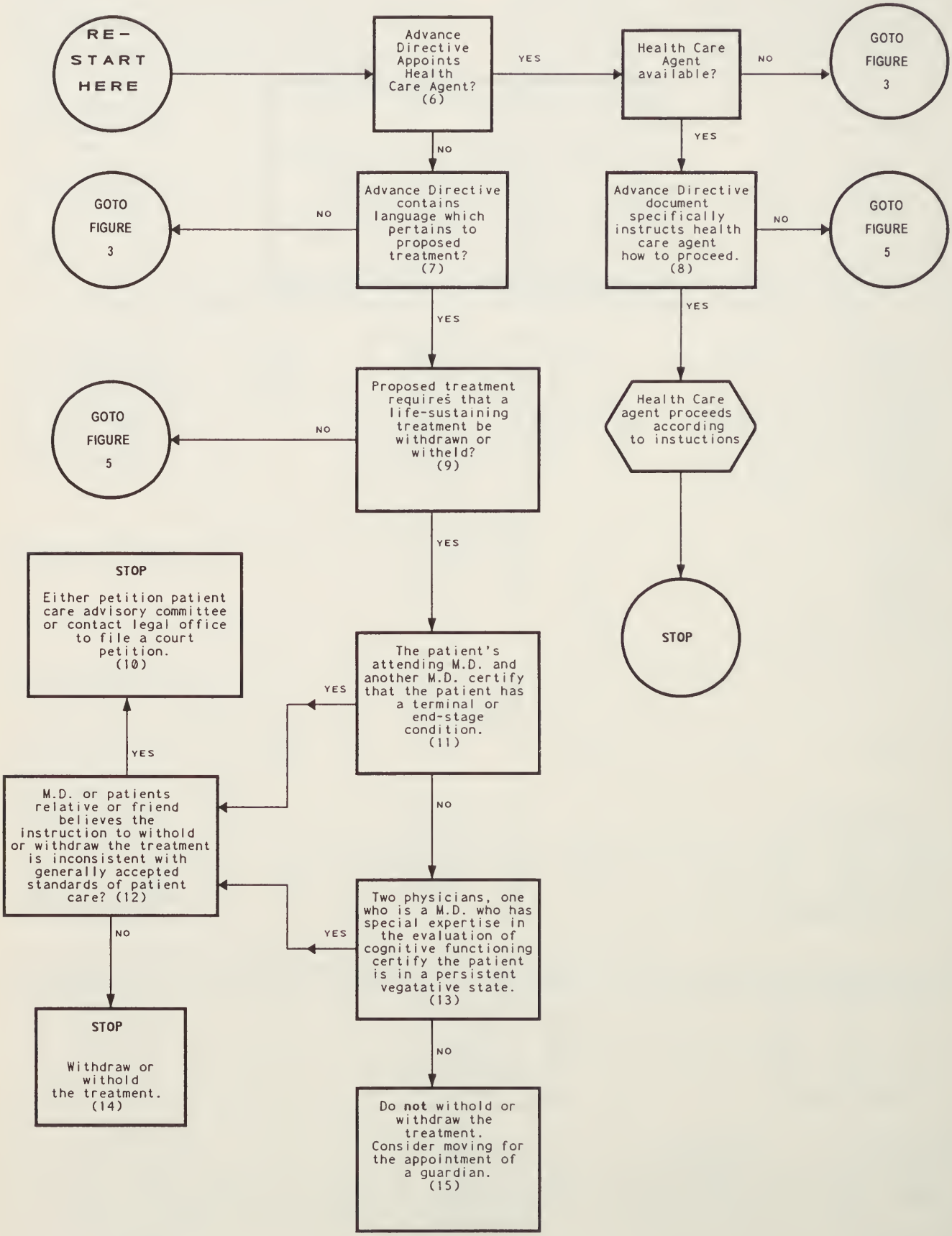

RE-START HERE
Advance Directive Appoints Health Care Agent? (6)
YES
Health Care Agent available?
NO
GOTO FIGURE 3
YES
NO
Advance Directive contains language which pertains to proposed treatment? (7)
NO
GOTO FIGURE 3
Advance Directive document specifically instructs health care agent how to proceed. (8)
NO
GOTO FIGURE 5
YES
YES
Proposed treatment requires that a life-sustaining treatment be withdrawn or witheld? (9)
NO
GOTO FIGURE 5
Health Care agent proceeds according to instuctions
YES
STOP
STOP
Either petition patient care advisory committee or contact legal office to file a court petition. (10)
The patient's attending M.D. and another M.D. certify that the patient has a terminal or end-stage condition. (11)
YES
YES
M.D. or patients relative or friend believes the instruction to withold or withdraw the treatment is inconsistent with generally accepted standards of patient care? (12)
NO
NO
Two physicians, one who is a M.D. who has special expertise in the evaluation of cognitive functioning certify the patient is in a persistent vegatative state. (13)
YES
NO
STOP
Withdraw or withold the treatment. (14)
Do not withold or withdraw the treatment. Consider moving for the appointment of a guardian. (15)

Figure 3.

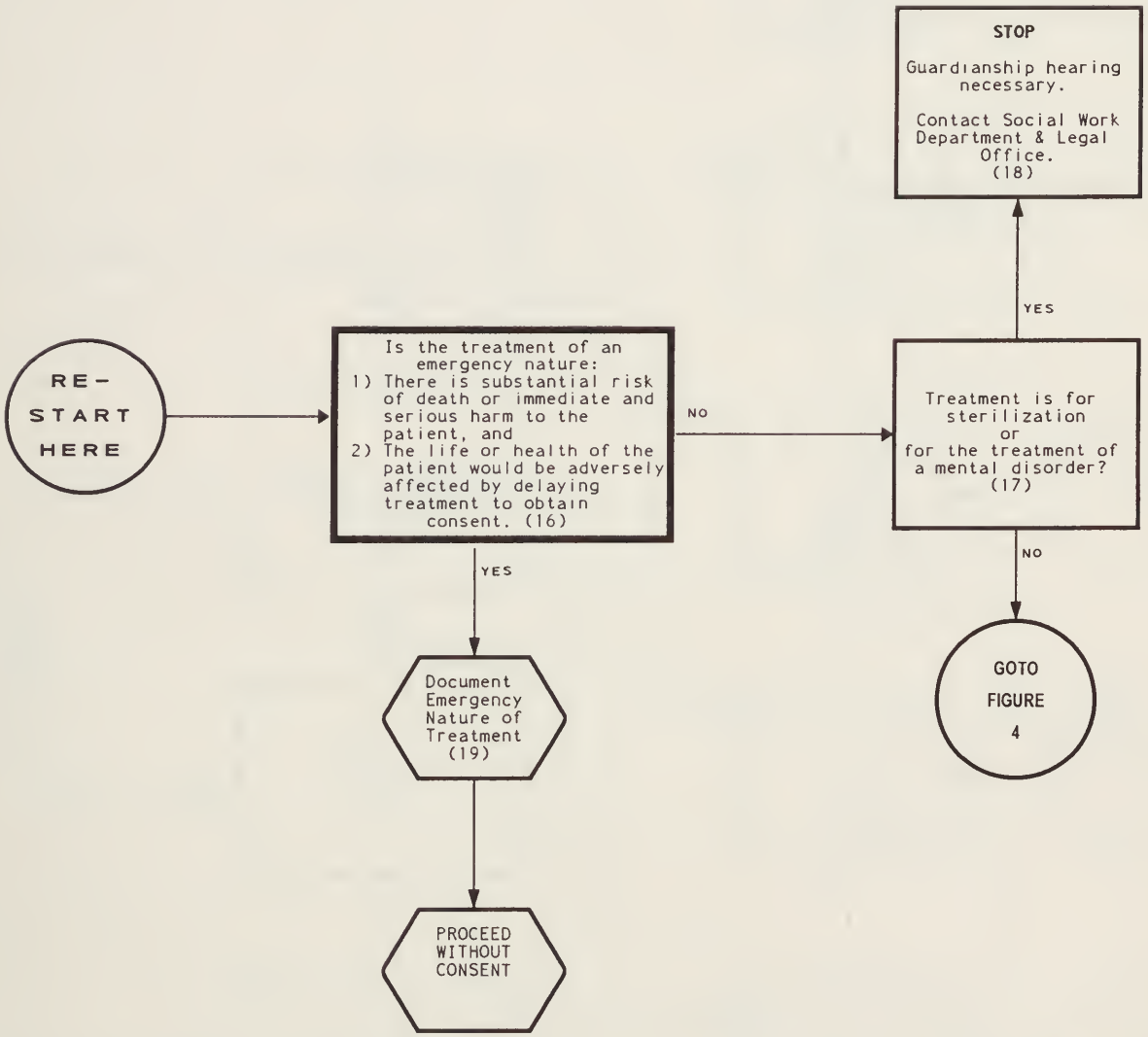

RE-
START
HERE
Is the treatment of an emergency nature:
1) There is substantial risk of death or immediate and serious harm to the patient, and
2) The life or health of the patient would be adversely affected by delaying treatment to obtain consent. (16)
NO
YES
Treatment is for sterilization or for the treatment of a mental disorder? (17)
YES
STOP
Guardianship hearing necessary.
Contact Social Work Department & Legal Office. (18)
NO
GOTO FIGURE 4
Document Emergency Nature of Treatment (19)
PROCEED WITHOUT CONSENT

Figure 4.

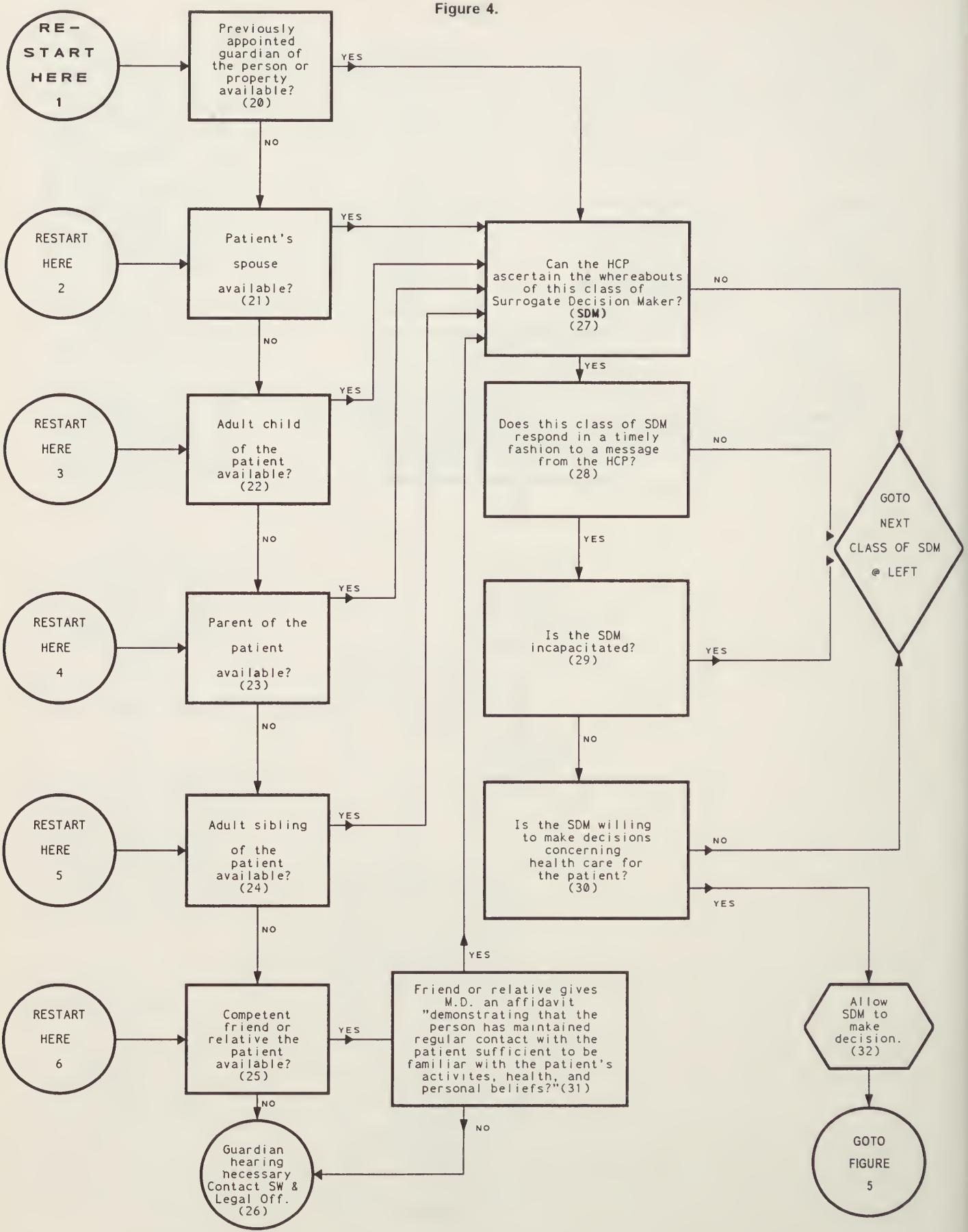

RE-START HERE 1
Previously appointed guardian of the person or property available? (20)
YES
NO
RESTART HERE 2
Patient's spouse available? (21)
YES
NO
RESTART HERE 3
Adult child of the patient available? (22)
YES
NO
RESTART HERE 4
Parent of the patient available? (23)
YES
NO
RESTART HERE 5
Adult sibling of the patient available? (24)
YES
NO
RESTART HERE 6
Competent friend or relative the patient available? (25)
YES
NO
Guardian hearing necessary Contact SW & Legal Off. (26)
Friend or relative gives M.D. an affidavit "demonstrating that the person has maintained regular contact with the patient sufficient to be familiar with the patient's activites, health, and personal beliefs?"(31)
YES
NO
Can the HCP ascertain the whereabouts of this class of Surrogate Decision Maker? (SDM) (27)
NO
YES
Does this class of SDM respond in a timely fashion to a message from the HCP? (28)
NO
YES
Is the SDM incapacitated? (29)
YES
NO
Is the SDM willing to make decisions concerning health care for the patient? (30)
NO
YES
GOTO NEXT CLASS OF SDM @ LEFT
Allow SDM to make decision. (32)
GOTO FIGURE 5

Figure 5.

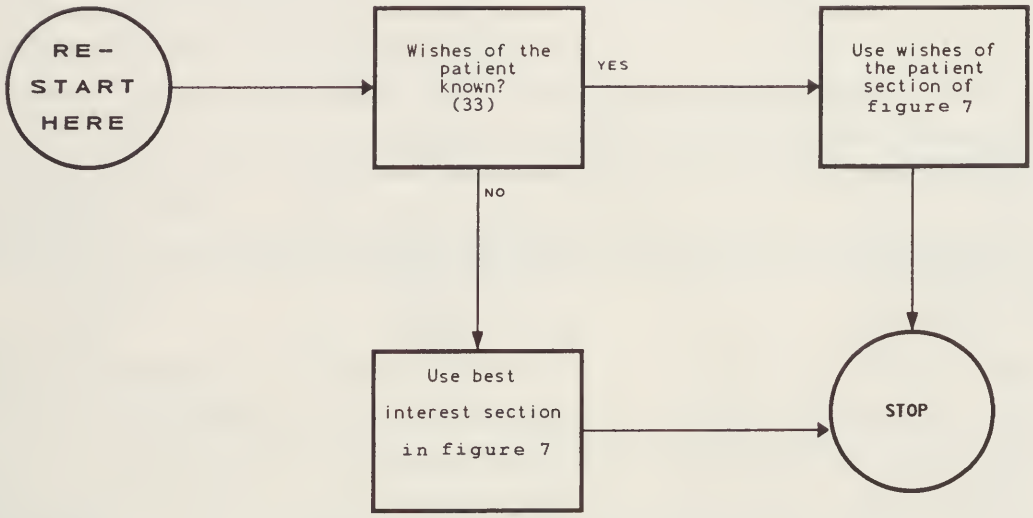

RE-
START
HERE
Wishes of the patient known? (33)
YES
Use wishes of the patient section of figure 7
NO
Use best interest section in figure 7
STOP

Figure 6.

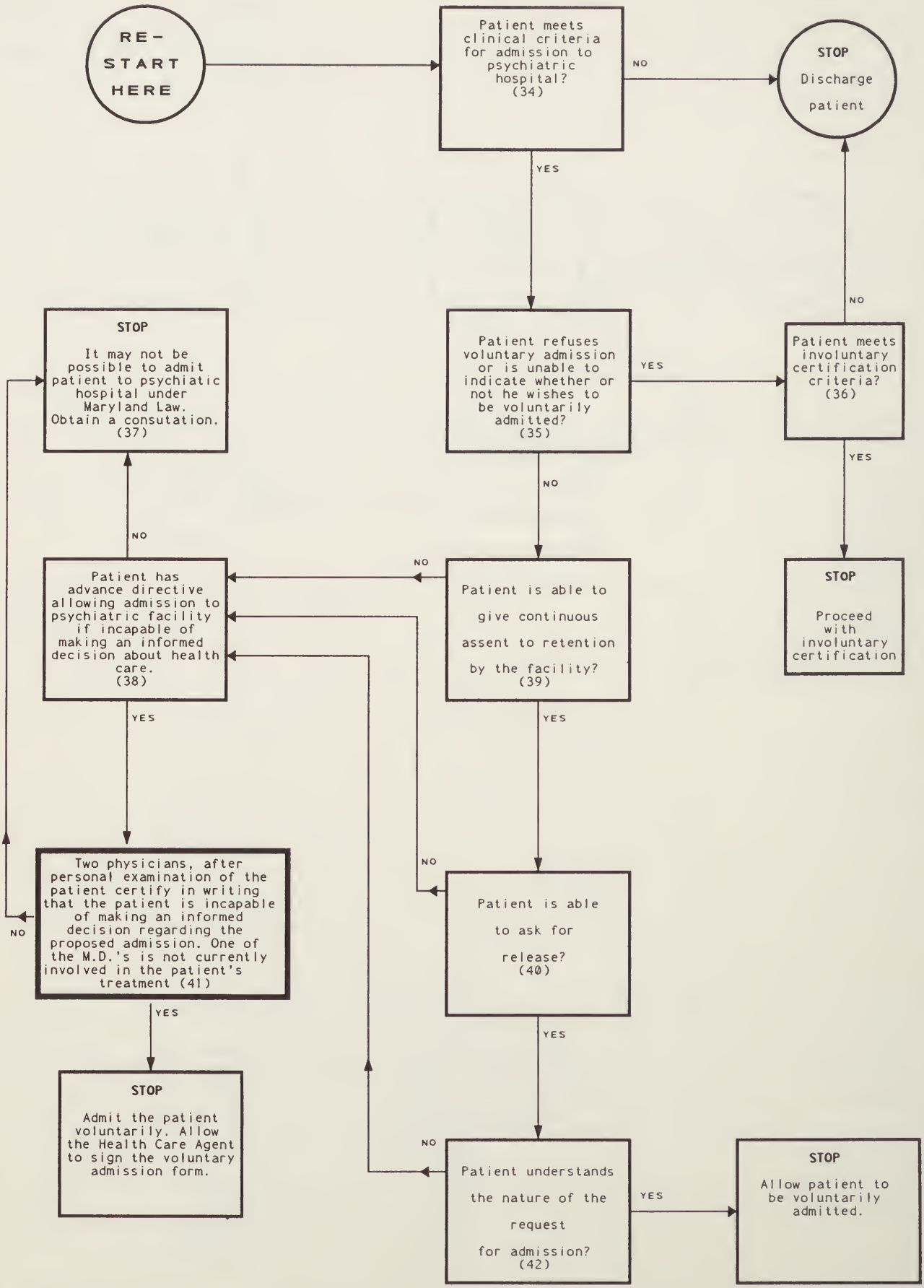

RE-START HERE
Patient meets clinical criteria for admission to psychiatric hospital? (34)
NO
STOP Discharge patient
YES
NO
STOP It may not be possible to admit patient to psychiatic hospital under Maryland Law. Obtain a consutation. (37)
Patient refuses voluntary admission or is unable to indicate whether or not he wishes to be voluntarily admitted? (35)
YES
Patient meets involuntary certification criteria? (36)
YES
NO
NO
Patient has advance directive allowing admission to psychiatric facility if incapable of making an informed decision about health care. (38)
NO
Patient is able to give continuous assent to retention by the facility? (39)
STOP Proceed with involuntary certification
YES
YES
Two physicians, after personal examination of the patient certify in writing that the patient is incapable of making an informed decision regarding the proposed admission. One of the M.D.'s is not currently involved in the patient's treatment (41)
NO
NO
Patient is able to ask for release? (40)
YES
YES
STOP Admit the patient voluntarily. Allow the Health Care Agent to sign the voluntary admission form.
NO
Patient understands the nature of the request for admission? (42)
YES
STOP Allow patient to be voluntarily admitted.

Figure 7.

Wishes of the patient

In determining the wishes of the patient the health care agent or surrogate decision maker should take the following into account:

- current diagnosis and prognosis with and without the treatment at issue; and
- expressed preferences regarding the provision of, or the withholding or withdrawal of, the specific treatment at issue or of similar treatment; and
- relevant religious and moral beliefs and personal values; and
- behavior, attitudes, and past conduct with respect to the treatment at issue and medical treatment generally;
- reactions to the provision of, or the withholding or withdrawal of, a similar treatment for another individual; and
- expressed concerns about the effect on the family or intimate friends of the patient if a treatment were provided, withheld, or withdrawn.
- *Not* based on either a patient's preexisting, long-term mental or physical disability or the patient's economic disadvantage.[43]

Best interest of the patient

In determining the best interest of the patient, the health care agent or surrogate decision maker should determine if the benefit to the individual resulting from a treatment outweighs the burdens to the individual resulting from the treatment, taking into account:

- the effect of the treatment on the physical, emotional, and cognitive functions of the individual; and
- the degree of physical pain or discomfort caused to the individual by the treatment, or the withholding or withdrawal of the treatment; and
- the degree to which the individual's medical condition, the treatment, or the withholding or withdrawal of treatment results in a severe and continuing impairment of the dignity of the individual by subjecting the individual to a condition of extreme humiliation and despondency; and
- the effect of the treatment on the life expectancy of the individual; and
- the prognosis of the individual for recovery, with and without the treatment; and
- the risks, side effects, and benefits of the treatment or the withholding or withdrawal of the treatment; and
- the religious beliefs and basic values of the individual receiving treatment, to the extent these may assist the decision maker in determining best interest.[44]

References

1. Md. Ann. Code, Health-General §5–601 to §5–618.
2. Folstein MF, Folstein SE, McHugh PR. Mini-mental state: a practical method for grading the cognitive state of patients for the clinician. *J Psychiatr Res* 1975;12:189–198.
3. *Zinermon v. Burch* 494 S. Ct. 975, 1990.
4. Md. Ann. Code, Health-General §10–609.
5. Md. Ann. Code, Estates and Trusts §13–706(a) and §13–708(b)(2).

Annotations (Figures 1-7)*

1. H.G. § 10–601 to § 10–619
2. H.G. § 5–601(l)
3. H.G. § 5–606(a)
4. Estates and Trusts § 13–708(b)(8)
5. H.G. § 5–611(e)(2). The exact language reads: "Nothing in this subtitle authorizes any action with respect to medical treatment, if the health care provider is aware the patient for whom the health care is provided has expressed disagreement with the action." On first reading it appears that this language would not allow a health care provider to provide health care for a patient, who while not clinically competent, vocalizes a refusal of a treatment which a surrogate decision maker or a health care agent has authorized. However, this did not make ethical or clinical sense. An opinion was sought from the Johns Hopkins Ethics Committee, which replied:

   "We interpret [the Health Care Decisions Act] to mean the patient's expressed wish occurred PRIOR to the patient's present incapacitated state. If that is correct, the committee agrees that what the law states is what is ethically appropriate: that we have a moral obligation to respect the expressed wishes of patients when they were competent.

If, however [the Health Care Decisions Act] is legally interpreted to mean that the patient is PRESENTLY refusing treatment while not having the capacity to give informed consent or by inference informed refusal, then the committee feels obligated to advise you that your moral obligation should be to act in the patient's best interest, and if the best clinical judgment is that the patient's best interest includes treatment that the patient is presently refusing, that this treatment be given.

If [the language in the Health Care Decisions Act] is legally interpreted to be a PRESENT statement of refusal of treatment while not having the capacity to give informed consent, there is a logical inconsistency in the law which is as follows. A different standard of surrogacy is implied for ACCEPTANCE of treatment as opposed to REFUSAL of treatment under these circumstances ... We are aware of no moral or logical basis for stating that there is a difference between informed consent and informed refusal" (Peter B. Terry, M.D., Chairman, The Johns Hopkins Hospital Ethics Committee, personal communication).

The language "[when previously competent]" was therefore inserted in the flow chart. Clinicians might consider consulting their own ethics committees for help in interpretation.

6. H.G. § 5-602(b)(1); H.G. § 5-601(c)
7. H.G. § 5-603
8. H.G. § 5-602(h)
9. H.G. § 5-606(b); H.G. § 5-601(m)
10. H.G. § 5-612
11. H.G. § 5-601(i); H.G. § 5-601(q); H.G. § 5-606(b)(1)
12. H.G. § 5-612(a-b)
13. H.G. § 5-606(b)(2); H.G. § 5-601(o)
14. H.G. § 5-612
15. H.G. § 5-606(b)
16. H.G. § 5-607
17. H.G. § 5-605(d)
18. H.G. § 5-605(d)
19. H.G. § 5-607
20. H.G. § 5-605(a)(2)(i)
21. H.G. § 5-605(a)(2)(ii)
22. H.G. § 5-605(a)(2)(iii)
23. H.G. § 5-605(a)(2)(iv)
24. H.G. § 5-605(a)(2)(v)
25. H.G. § 5-605(a)(2)(vi)
26. Estates and Trusts §13-704
27. H.G. § 5-605(a)(ii)
28. H.G. § 5-605(a)(iii)
29. H.G. § 5-605(a)(iv)
30. H.G. § 5-605(a)(v)
31. H.G. § 5-605(a)(3)
32. H.G. § 5-605
33. H.G. § 5-605(c)
34. H.G. § 10-609(c)(1&2)
35. H.G. § 10-617(a)(4)
36. H.G. § 10-617(a)(1-5)
37. *Zinermon v. Burch* 494 S. Ct. 975,1990
38. H.G. § 5-603
39. H.G. § 10-609(c)(4)
40. H.G. § 10-609(c)(5)
41. H.G. § 5-601(l); H.G. § 5-606(a)
42. H.G. § 10-609(c)(3)
43. H.G. § 5-605(c)
44. H.G. § 5-605(c); H.G. § 5-601(e)

* H.G. = Annotated Code of Maryland, Health-General Article
Estates and Trusts = Annotated Code of Maryland, Estates and Trusts Article ■

STARK II

As of January 1, 1995, complex federal legislation known as Stark II went into effect. An extension of Stark I, it prohibits Medicare and Medicaid reimbursement for physician referrals of designated services to an entity with which the physician or a family member has a financial arrangement. Designated services are

- clinical laboratory services;
- physical therapy services;
- occupational therapy services;
- radiology, magnetic resonance imaging, computed axial tomography, and ultrasound services;
- durable medical equipment;
- parenteral and enteral nutrition, equipment, and supplies;
- prosthetics, orthotics, and prosthetic devices;
- home health services;
- outpatient drugs;
- inpatient and outpatient hospital services.

Financial arrangements include both ownership interests and compensation arrangements. There is no minimum investment criteria; any level of investment or ownership apparently may constitute a financial interest. In addition to traditional methods of compensation (e.g., salary, personal service agreements, recruitment incentives), the statute includes "any remuneration, directly or indirectly, overtly or covertly, in cash or in kind." Stark II contains numerous, often complex exceptions that may not be clarified until the Health Care Financing Administration issues the regulations implementing the new law. According to AMA sources, however, the regulations will not be issued for at least two months and may not be available until June. Nevertheless, compliance with the law is mandatory and will be enforced. Penalties include a civil monetary penalty of up to $15,000 for each violation and exclusion from participation in Medicare and Medicaid programs.

Any willing provider laws: what do they mean to Maryland physicians?

Susan D. Baker and Andrew L. Jiranek

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As ever greater numbers of Americans receive health care through health maintenance organizations (HMOs) or preferred provider organizations (PPOs), participation in these networks has become increasingly important to physicians and other health care providers to maintain a sufficient patient base. To limit the ability of insurers to restrict their networks, health care providers in many states, including Maryland, have sought enactment of "any willing provider" (AWP) legislation. AWP laws seek to prevent arbitrary and unreasonable exclusion of providers from networks.

In Maryland, by year-end 1993, 32% of the population was enrolled in HMOs and 15.7% was enrolled in PPOs.[1] As these percentages increase, competition among Maryland providers for network inclusion will intensify.

AWP laws comprise four broad categories. The first category contains "freedom of choice" laws that require insurers to reimburse a non-network provider as long as the provider agrees to accept the insurer's level of reimbursement for the service. The second category contains "mandatory admittance" laws that require insurers to include in a network any provider willing to abide by the terms and conditions of the network, including price. The third category contains "due process" laws that require insurers to follow certain procedures in creating and maintaining a network, such as publishing the criteria for participation in the network and providing for an appeal in the event of termination. The fourth category contains "essential community provider" laws that require insurance networks to contract with essential community providers that serve medically needy, poor populations (e.g., community health centers and AIDS providers).

AWP legislation in Maryland

Maryland has had a very limited AWP law since 1969. Section 354A of the Insurance Code requires a nonprofit health plan that provides pharma-

ceutical services to grant to any policy holder the right to have any prescription filled at the pharmacy of the policy holder's choice. During the 1994 legislative session, the Maryland General Assembly debated two AWP bills that would have been substantially broader. The House and Senate each failed to pass "mandatory admittance" AWP bills. The Senate also considered but failed to pass a "due process" AWP bill. The "due process" AWP bill would have required an insurer to

- establish and disclose to the public criteria for selecting health care providers into its network;
- notify an applicant upon acceptance into the network within 60 days;
- notify excluded applicants of the criteria used to make the decision; and
- continue to reimburse a provider for 60 days after the carrier terminates a provider's contract without good cause.

The Maryland Legislature did pass a bill authorizing creation of an Interagency Task Force on Health Care Networks to study the impact and growth of health care delivery networks in Maryland. Governor Schaefer vetoed the legislature's action, but authorized creation of a task force with his designees by executive order. Task force members include insurance company representatives, physicians, other health care providers, and legislators. One of the task force's charges was to study the impact of AWP legislation in other states.

On December 1, 1994, the governor's task force issued an interim report recommending that HMOs and other networks be allowed to screen applicants as long as they follow their published selection criteria—but not be forced to accept "any willing provider." Selection criteria would include quality, ability to control costs, and a particular provider's utilization patterns. Networks would be required to accept or reject an applicant within 60 days, and rejected applicants would have 30 days to appeal.[2] It is likely that some type of AWP legislation will be introduced during the General Assembly's 1995 session.

Of course, Congress could enact legislation preempting state laws in this area. AWP laws were a part of almost every major federal health care reform proposal in 1994. President Clinton's Health Security Act, as well as bills introduced by Senators Mitchell and Gephardt, would have preempted state AWP laws. A Republican Congress, however, may be more sympathetic to the insurance industry.

Supporting and opposing arguments

Proponents of AWP laws assert that such laws are designed to preserve the right of patients to choose their own physician and to prohibit networks from limiting provider participation based solely on economic factors, such as price discounts or the provider's patient mix. In addition, proponents argue that AWP laws prevent insurers from gaining the type of bargaining leverage that allows them to dictate patient care decisions to a provider, decisions that are not necessarily based on the individual needs of the patient.

Insurance companies and HMOs that oppose AWP laws argue that such laws interfere with a health plan's ability to contract with providers and assure a patient volume sufficient to generate price discounts for its policyholders. Opponents also argue that AWP laws increase administrative costs by forcing health plans to credential a larger number of providers than would otherwise be admitted and by saddling health plans with unneeded providers whose practice patterns must be monitored. Finally, opponents contend that AWP laws promote the current oversupply of specialists and shortage of primary care physicians by restricting a health plan's ability to limit the number of specialists within its network.

So far, studies of AWP laws support the argument that the laws increase the cost of health care. Health insurance trade associations commissioned two studies, one by Wyatt Co. (1991)[3] and another by Atkinson & Co. (1994).[4] Both were based on economic models (which the American Medical Association has challenged) developed by the authors. The Wyatt study concluded that AWP laws increased administrative costs anywhere from 34% to 52%, and the Atkinson study concluded that costs increased from 43% to 127%. The studies also found that a typical managed care organization lost 8.8% to 14.2% (Wyatt) and 5.8% to 18.4% (Atkinson) in claim savings from AWP laws.

The House Appropriations Committee of the Florida General Assembly commissioned a third study by Arthur Andersen & Co.[5] In its report, Andersen concluded: "[P]ayors would have far less leverage to negotiate fees with physicians. In addition, utilization management programs would be spread over a far greater number of physicians, diluting their effectiveness and focus. The combination of these effects would eliminate much or all of the cost savings achievable through managed care. Furthermore, administrative expenses would increase, due to greater network size."

In addition to these studies, a number of state legislatures requested the U.S. Federal Trade Commission (FTC) for advice about the possible impact that AWP laws could have on competition and health care costs. The FTC has consistently concluded that "any willing provider requirements may discourage competition among providers, in turn raising prices to consumers and unnecessarily restricting con-

sumer choice in prepaid health care programs, without providing any substantial public benefit."[6]

Notwithstanding these studies and opinions, AWP legislation has increasingly become law at the state level. Between 1983 and 1993, 16 states adopted AWP laws, and in 1994, 9 more states did so. Of these 25 states, the AWP laws of 8 states apply to all or most classes of health care providers; the AWP laws of 17 states apply only to pharmacy services.[7,8]

Court treatment of AWP legislation

A number of court actions have tested state AWP laws. These actions have generally been unsuccessful.

A Texas federal district court recently rejected the claim of a group of doctors that Aetna had violated Texas' AWP statute by excluding them from a PPO.[9] The Texas statute requires that decisions regarding inclusion in a network be "based solely on economic, quality and accessibility considerations, and shall be applied in accordance with reasonable business judgment." In dismissing the case, the court did not address the reasonableness of the insurer action. Instead, the court determined that the statute only created a cause of action in favor of the Texas Board of Insurance, and not private parties.

In three Virginia cases, hospitals unsuccessfully sued insurers alleging that decisions excluding or terminating the hospital violated Virginia's AWP statute. Virginia's AWP statute applies only to PPOs, not HMOs, and covers virtually all health care providers. Virginia's AWP statute allows insurers to limit the numbers and types of health care providers in its network provided (i) the insurer establishes terms and conditions required to be met by a provider; and (ii) the terms and conditions do not "discriminate unreasonably against or among health care providers." No provider willing to meet the terms and conditions may be excluded; however, "differences in prices among hospitals or other institutional providers resulting from individual negotiations or based on market conditions or price differences among providers in different geographical areas are not deemed to be unreasonable discrimination."[10]

The Virginia cases provide some guidance regarding how an insurer may restrict its network without violating AWP laws. In a 1990 case, H.C.A. Health Services challenged the exclusion of its hospital subsidiaries from MetLife's PPO network in federal district court, arguing that MetLife had unreasonably discriminated against the hospitals in violation of Virginia's AWP statute.[11] MetLife selected hospitals participating in MetElect using a two-step process. MetLife first developed a short list of hospitals based on a comparative evaluation of hospitals. The comparative evaluation used the following selection criteria: geographic location relative to covered population; range of services; cost efficiency; historical utilization; willingness to comply with medical management and utilization review; anticipated level of medical staff's interest in the network; strength of staff; and price. MetLife excluded certain hospitals that did not meet these criteria. In the second step of its selection process, MetLife negotiated prices with individual hospitals on the short list.

The court ruled for MetLife, finding that Virginia's AWP statute does not prohibit all discrimination among providers, but only unreasonable discrimination. The court recognized that insurers must limit networks to win volume discounts from providers. The court upheld the insurer's right to exclude providers from the short list if they did not meet the selection criteria.

A Virginia state court subsequently ruled that Blue Cross and Blue Shield of Virginia (BCBS) did not discriminate unreasonably in excluding St. Mary's Hospital from its PPO.[12] The court found that the exclusion was not unreasonable because it worked to the overall benefit of the PPO enrollees. Another hospital network offered services at a greater discount and with broader geographic coverage.

In the most recent case, a federal district court ruled that Aetna did not violate the AWP law in excluding Reston Hospital from its network.[13] The court previously had ordered Aetna to negotiate with Reston, finding that Aetna had initially failed to conduct a "thorough comparative analysis of potential providers." However, the court rejected the hospital's argument that Virginia's AWP statute requires the insurer to consider individual hospital factors only. The court's holding permits the insurer to consider whether the individual provider will contribute to the network's cost and service goals.

The Virginia cases represent a judicial effort to balance the insurer's need to restrict membership in a network with protection of patient choice. In the cases, courts did not require an insurer to include a provider that failed to meet the needs of the insurer's network. The decisions permit an insurer to develop a short list of eligible providers with whom it will negotiate, provided that a "thorough comparative analysis" is used to develop the short list.

The three Virginia opinions all involve exclusion of hospitals from a network. Applying these opinions to other providers, however, could be more difficult. Before any price negotiation, an insurer is required to

- identify all providers in a targeted geographic area authorized to provide a particular service;

- identify the service area of each provider;
- identify the number of individuals covered by the plan served by each provider; and
- calculate the cost efficiency of each provider.

This information is obviously far more difficult to compile for individual providers than for hospitals.

These cases do not indicate whether an insurer may include "network capacity" in its terms and conditions, nor do they establish whether, if an insurer determines that its capacity is full, the insurer is authorized not to accept providers who meet other professional and economic criteria.

Burdened with the cost of defending enforcement actions based on AWP laws, insurers have unsuccessfully tried a preemptive strike by arguing that the Federal Employee Retirement Income Security Act of 1974 (ERISA) preempts Virginia's AWP statute. A federal court of appeals rejected the argument, finding that under ERISA's insurance savings clause, ERISA does not preempt state statutes that regulate the business of insurance.[14] The court concluded that the AWP statute regulated the business of insurance because it is aimed at protecting or regulating the relationship between the insurance company and the policyholder. The purpose of the statute was to prohibit unreasonable restriction by the insurer of the insured's choice of physician and hospital. The court stated: "If a PPO unreasonably restricts the providers of treatment, even though they meet the insurer's standards, it denies an insured the choice of doctor or hospital that may best suit the insured's needs, unless the insured is willing and able to pay all or part of the cost of the doctor or hospital that is not preferred by the insurer.[15]

In rejecting the insurance company's argument that the Virginia statute merely facilitated the exchange of goods and services and did not regulate the business of insurance, the court found that in enacting the statute the legislature had given priority to the insured's freedom to choose doctors and hospitals over the possibility of reduced insurance premiums.

Perhaps frustrated by their inability in the courts and state legislatures to prevent AWP legislation from becoming law, insurers have pointed to AWP law enforcement actions as an additional reason why AWP laws are harmful. Insurers argue that the costs of lawsuits associated with AWP laws must be added to the overall costs of developing and administering networks. Such costs ultimately must be recouped through premiums.

Elimination of AWP laws, however, may not necessarily eliminate litigation costs and resulting premium increases. In several cases, physicians have challenged network exclusion on grounds other than violation of AWP statutes. The District of Columbia chapter of the American Medical Association and several individual physicians sued Blue Cross and Blue Shield of the National Capital Area based on exclusion from a PPO.[16] The suit, in which motions to dismiss are currently pending, includes defamation and misrepresentation counts, in addition to a count based on Virginia's AWP law. In a California case, a physician challenged network exclusion based on a common law claim for interference with professional practice.[17] The court ruled in favor of the health plan, finding that the plan's credentialing standard was rationally based and procedurally sound.

Conclusion

Whether AWP laws are enacted at the federal or state level, it is likely that insurers and providers in Maryland will be affected by changes in AWP laws. Properly structured, AWP laws can balance the need for health insurers to limit provider networks with the needs of health care providers and patients.

In the meantime, Maryland physicians can take steps to protect themselves from arbitrary insurer action. Providers who propose to enter into HMO/PPO contracts should seek contract provisions restricting insurer termination rights. Such provisions would give the insurer the right to terminate only if the provider fails to meet objective performance standards. The provisions would also require notice of termination and a right to appeal.

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RESTRICTING MEDICAL EXPERT WITNESS FEES

Few Maryland court cases have defined or limited reasonable medical fees. In 1993, however, a Montgomery County circuit court judge issued a decision regarding appropriate charges for medical expert witness fees for the taking of a deposition.[1]

The case involved an orthopedic surgeon who charged $750 for a deposition that lasted less than one hour. The court stated that the deposition fee exceeded by 200% to 300% the fee ordinarily charged by the physician for medically related services involving the same amount of time, but not involving attorneys. Finding the fee excessive, the court defined the limit for such charges to be the same as what the physician could have earned during the same time period for services rendered in his medical office. The court did note that if the deposition lasted even one minute longer than one hour, the physician could bill a reasonable fee for an entire additional hour.

The court also held that the physician's demand for prepayment of fees was unreasonable because such a practice "has had, and will continue to have, the effect of interfering with the proper administration of justice and will thereby inhibit access to the court by litigants who require the testimony of treating physicians." The judge felt that 60 days was an appropriate time for payment following a deposition.

The court concluded that "when the health care provider is purely a fact witness and is not taken from his/her normal avocation (not an expert witness), no fee shall necessarily be required for the time involved by the health care provider in deposition."

Because the case was not appealed to a higher court, it is not considered binding on other circuit court judges. The reasoning in the case, however, can be used as precedent in other litigation fee disputes. Thus, the decision could have far-reaching consequences and may be extended in the future to fees for medical reports and court testimony. The determination of reasonable fees for services of physicians in the litigation process is likely to come under increasing scrutiny. A full disclosure in advance of the fee to be charged, with specific written consent, is always the preferred method of setting and being able to collect the fee.

From a paper presented at a continuing medical education seminar sponsored by the Prince George's County Medical Society, November 1994.

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The future exemption from tax of health care providers

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In the wake of national health care reform, the status of health care providers that are exempt from income tax under Section 501(c)(3) of the Internal Revenue Code of 1986 (the Code) and correlative state statutes [collectively, 501(c)(3)] has been called into question. The crux of the matter is whether the distinction between for-profit institutions and their nonprofit counterparts is clear enough to merit continued exemption from federal and state income taxes. For-profit institutions claim that their nonprofit counterparts enjoy an unwarranted competitive advantage, while nonprofit providers continue to highlight their qualitative differences from their for-profit counterparts.

The evolution of exempt status for nonprofit hospitals

The prior and current Codes do not specifically include hospitals as exempt organizations. The Code states that "corporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, . . . or educational purposes" is exempt from taxation, but institutions that provide health care services are not mentioned.[1] Because hospitals were originally almshouses, they were deemed "charitable" and were thereby granted exempt status and the favorable benefits that accompany it.[2]

In 1956, the Internal Revenue Service issued Revenue Ruling 56-185 to clarify the requirements that a nonprofit hospital must fulfill in order to retain its tax-exempt status. The requirement of that ruling most pertinent to the current debate provides that a hospital "must be operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay."[3] This requirement has been interpreted to require care for indigents, which comports with the common understanding of the word *charitable*.

In 1969, the IRS replaced the 1956 standard (providing free or below-cost care to the poor) with a community benefit standard (Revenue Ruling 69-545)[4] that significantly loosened the requirements for obtaining and retaining exempt status. The new ruling allowed nonprofit hospitals to maintain an emergency room open to all regardless of ability to pay.[2] As a result, the definition of "charitable" changed from care given to those who could not otherwise afford it to "the promotion of health."[2]

In 1983, the IRS issued Revenue Ruling 83-157, which held that the operation of an emergency room open to all regardless of ability to pay was no longer required if it would result in an unnecessary duplication of services (e.g., availability of an emergency room at a nearby hospital).[2] Thus, the current standard is whether the hospital "primarily benefits the community."[5]

The current standard has failed to provide any meaningful guidance by which to judge whether a nonprofit hospital merits exempt status. No 501(c)(3) hospital has had its exempt status revoked for failure to meet the community benefit standard.[6] Other than taxing any unrelated business income of an exempt organization, the IRS has only one available remedy for tax exemption abuses: revocation of exempt status, a rather harsh penalty that, among other things, would prevent donors from claiming charitable contribution deductions. Perhaps that is one reason why the IRS is reluctant to revoke exempt status.

Although almost nothing is left of the accepted understanding of the word *charitable* as it applies to nonprofit hospitals, they continue to enjoy the benefits of exemption.[7] Today, these benefits include exemption from federal and state income taxes, charitable contribution deductions for donors, exemption from property taxes in most states, favorable postal rates, and tax-exempt bond issuances,[8] benefits (or inducements) not available to for-profit health care providers.[6] These benefits will amount to approximately $19.6 billion in lost tax revenues for 1994-1998 for charitable contribution deductions under the federal income tax laws and exempt bond issuances alone.

Arguments against exemption

Critics of tax exemption for nonprofit hospitals and proponents of health system reform argue that if universal coverage becomes a reality, the need for charity care, and thus exemption, will no longer exist.[6] Eliminating the exemption would generate approximately $8 billion in revenue that could help to alleviate the problems of financing a health care reform package.[9] This argument, however, is misplaced for two reasons. First, charity care as it is commonly understood is no longer the basis for exemption. Second, since "promotion of health" is the current basis for exemption, then health care reform will not alter the nonprofit hospital's function of promoting health. Thus, a more suitable inquiry would focus on the essential substantive or qualitative differences between for-profit hospitals and their nonprofit counterparts to determine if exemption is still warranted.[6]

Distinctions between for-profit and nonprofit health care providers

Community benefits. Nonprofit hospitals must highlight characteristics that distinguish them from for-profit hospitals. One proposal would require exempt providers to conduct an annual community needs assessment and to formulate, with community participation, plans to meet those needs.[6]

Some state legislatures are strengthening their community benefit standard for exempt status. In Texas, for example, the courts must consider the "unreimbursed cost of (1) charity care, (2) Medicaid, (3) donations, (4) education, (5) research, (6) Medicare, and (7) subsidized health services."[6]

Use of tax-exempt bonds. Critics claim that nonprofit health care providers take unnecessary advantage of their ability to issue tax exempt-bonds, often using them to expand facilities when the institutions are presently running below capacity.[6] The government will lose approximately $10.8 billion in income tax revenue through these financings from 1994 to 1998.[6] To counter this criticism, proponents of continued exemption may suggest limiting the types of projects financed with exempt bonds.[6]

Teaching and research. Compared with for-profit providers, nonprofit providers receive the majority of the National Institutes of Health research grants and engage in the majority of teaching activities through residency programs.[10] Because 501(c)(3) grants exemption to educational and scientific organizations, nonprofit hospitals may otherwise warrant their exemption for these pursuits.[1]

Expenditure of excess revenue. Competition with for-profit hospitals has forced the boards of directors and administrative and financial staff of nonprofit hospitals to focus on the bottom line.[9] Nonprofit providers attempt to generate revenue to cover the costs of operation as well as to increase and improve technology, facilities, and programs. Criticism by for-profit providers, who also must keep up with technology and provide suitable facilities, would be understandable if exempt providers merely invested excess revenue in capital reserves. Nonprofit providers may alleviate some criticism by spending the revenue in a manner that "promotes health."

Tax-exempt health maintenance organizations

Over the past several years, the financing of health care has shifted from indemnity insurance to managed care.[6] Health maintenance organizations both provide and insure health care services.[8] The four basic types of HMOs include:

- the staff model, which provides services by its own physicians at its own facilities;
- the group model, which provides services at its own facilities or a central location by physicians in a group practice;
- the individual practice association (IPA) model, through which the HMO contracts with the physicians who provide services at their own facilities; and
- the network model, which provides services through a network of practice groups.[8]

The different types of HMOs have received varied tax treatment. The staff and group models may qualify for 501(c)(3) status; the IPA model may qualify for 501(c)(4) exempt status as a "social welfare" organization; and it is doubtful that the network model qualifies for either exemption.[8] These distinctions, however, are questionable. If the standard for exemption is the promotion of health, and HMOs promote health, why should certain models qualify for exemption while others do not? Supporters of the varying standards explain that the group and staff models actually provide health care while the other models simply "arrange" for health care.[10] For-profit health care insurers raise the same complaints against tax-exempt HMOs that for-profit hospitals raise against nonprofit hospitals: unwarranted exemption from taxation results in a competitive advantage. The Blue Cross and Blue Shield Association, for example, argues that all HMOs should pay income taxes.[6]

Some health care reform plans attempt to codify the IRS determination that staff and group model HMOs qualify for charitable exemption under 501(c)(3). Such plans also require tax-exempt HMOs to conduct an annual community needs assessment.[6]

Conclusion

Industry-wide revocation of exempt status for nonprofit health care providers would be a "punishment" worse than the "crime." Nevertheless, to prove that they have earned the benefits of exemption, 501(c)(3) health care providers should highlight the qualitative aspects that differentiate them from for-profit providers.[6]

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PHYSICIAN LIABILITY FOR LABORATORY TESTS

In November 1994, the Maryland Medicaid Fraud Control Unit earned a guilty verdict against a Baltimore County-based medical laboratory and its owner for deceptively marketing high-profit clinical laboratory tests to physicians. The laboratory's requisition forms had offered groups of tests called profiles, which included one or more exotic tests in addition to the commonly requested test panel (SMAC or Chem). Believing that test profiles are the most economical means of ordering diagnostic tests and that the extra tests did not increase the cost, physicians routinely ordered the profile whenever they needed any of the tests in the SMAC panel. In fact, the laboratory billed the insurer separately for the exotic tests, which cost the insurer four or five times as much as the SMAC panel. In almost all cases, the exotic test results were not needed and were ignored by the physicians.

Although previous prosecutions have focused only on the culpability of laboratories, in the case above the court stated that physicians shared in the responsibility for the billings to the insurers because the requisition forms clearly listed the exotic tests included in the profiles. To avoid potential liability, physicians should:

- Ask the laboratory to provide a complete price breakdown for profiles and panels, including the CPT codes and amounts billed. (Because laboratories may have different fee schedules for bills to physicians and bills to insurers, physicians should request all information relevant to their contract with the laboratory.)
- Order a profile or panel containing separately billed components only if each component is necessary for treating the patient.
- Ask the laboratory to customize a profile for general screening purposes if it does not already offer what the physician wants.
- Question the receipt of results for tests that were not ordered (it is illegal for a laboratory to perform a test without authorization).

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Health Resources Planning Commission regulation of ambulatory surgical care

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Economic and technological factors have combined to encourage the development of freestanding centers where ambulatory surgery is performed. These centers have been highly competitive with hospitals. Over the past five years, there has been pressure to regulate the freestanding centers extensively, primarily through Maryland's Health Resources Planning Commission, which currently has authority to issue Certificates of Need for the development of multispecialty and some single-specialty ambulatory surgery centers. This article reflects the position of the Medical and Chirurgical Faculty of Maryland regarding regulation and development of these centers and highlights the expected continuing discussions and developments before the Maryland Health Resources Planning Commission and the legislature.

The Health Resources Planning Commission (HRPC) and the Certificate of Need (CON) process were created by the Maryland General Assembly in 1982. The general purpose of the legislation is to "promote the development of a health care system that provides, for all citizens, financial and geographic access to quality health care at a reasonable cost." This purpose is to be achieved by identifying health resources and health care needs, and centralizing planning to match the resources with the needs, as much as possible.

Certificate of Need

The basic tool given to the HRPC to achieve this purpose is the CON. The HRPC, after evaluating information made available to it, issues an annual health plan assessing need for specific health services throughout Maryland. No new health care facility may be opened without a CON. Potential owners

and operators of such facilities, throughout each year, file applications for CONs, which are evaluated in light of the health care plan. At present, at least in the central Maryland area, the health plan shows full capacity of existing surgical facilities. Thus, to the extent that the HRPC adheres to customary need analysis, new certificates will be difficult to obtain in the foreseeable future.

Under the statute, health care facilities include hospitals or related institutions; multispecialty or large single-specialty ambulatory surgery centers (ASCs); and various home health agencies, inpatient facilities, hospices, and the like. When the HRPC enabling act was amended in 1986, the following subset of ambulatory centers was "defined out" of the law:

> The office of one or more private physicians, podiatrists or dentists, regardless of whether such office is eligible or receives reimbursement from third party payers as an ambulatory surgical facility or center, if that office provides services only within a single medical or surgical subspecialty as determined by the Health Resources Planning Commission in regulation, if the office is used only for the physician's patients or patients of the group, and if the office includes not more than 4 surgical suites.[1]

A subsection subsequently was added specifically naming ophthalmology as a subspecialty.

Also exempt from the definition of facility are ASCs that do not seek reimbursement from third party payers as ASCs. The exception primarily applies to ambulatory centers where elective plastic surgery is performed.

A proper interpretation of the "office" single-specialty exception would exclude from CON requirements *any* single-specialty office with fewer than five surgical suites and owned and operated by a single physician or group of physicians. The HRPC, however, interprets the law so that *it* decides which surgical specialties or subspecialties, otherwise meeting these criteria, are exempt from CON requirements. In the mid-1980s, it promulgated a list of ten such exempt specialties (colon and rectal surgery, dermatology, gynecology, ophthalmology, oral surgery, otolaryngology, plastic surgery, podiatric surgery, vascular surgery, and neurological surgery).[2]

Changing economics

The CON system does not work well in a partially regulated system with a dichotomy between a cost-based payment system for hospitals and a competitive economy for everyone else. Rapid advances in technology and surgical practice have led to a great increase in the kind of surgical procedures that can be performed in an ambulatory setting, while payments have responded to competition in this unregulated market. At the same time, Maryland's unusual all-payer system for setting hospital rates has artificially supported the cost of hospital-based ambulatory surgery. In addition, there is evidence that many patients are comfortable with ambulatory surgery in a freestanding facility. Managed care organizations have contracted widely with freestanding ambulatory facilities, and many now only permit ambulatory surgery to be performed outside a hospital setting. Even Medicare requires that all routine endoscopy be performed in ambulatory facilities.

As a result, there has been a proliferation in freestanding ambulatory surgical capacity. Hospitals that substantially expanded inpatient and ambulatory surgical capacities expecting to perform more of this type of surgery have suffered financially because of the shift away from hospital-based facilities. Although there has not been a proliferation of multispecialty freestanding ambulatory surgical centers or single-specialty facilities subject to CON requirements, there has been substantial pressure for "letters of exemption" from the HRPC for office-based facilities of a single-specialty nature that are statutorily exempt from CON requirements.

Issues

Because of great pressure from hospital interests, the HRPC has tried to slow or stop the development of single-specialty ASCs through regulatory control. Early in 1994, HRPC staff instituted a study of the ambulatory surgery issue from its perspective. Initial reports of the study, as they emerged at Commission hearings during the summer, tended to show that freestanding ambulatory surgery facilities are safe, effective, and inherently more efficient than hospital-based facilities. A preliminary report issued September 27, 1994, contained findings and recommendations that, if accepted by the General Assembly, could have been the demise of non-managed-care operated, non-hospital based ambulatory surgery facilities altogether, with the possible exception of those already in existence. After a hearing at which extensive testimony was taken from both hospital and freestanding ambulatory care representatives, however, a second HRPC report modified or withdrew some of the more repressive recommendations.

Capacity vs. utilization. The issues that have created the most confusion and misunderstanding in this area are those of "capacity" and "utilization." As defined in the HRPC's annual health plan, "need" is largely determined by percentage utilization of existing facilities—that is, capacity. In a cost-based payment system such as that created by the Health Services Cost Review Commission for hospitals under Maryland's all-payer system, excess capacity can result in inflated payments for health care, since the cost of building and maintaining expensive surgical facilities is passed on directly to the consumer regardless of supply and demand. In a competitive

market economy where services are scrutinized though utilization review and payments depend on appropriate utilization, an oversupply of capacity should result in lower costs, using traditional supply and demand curve analysis. There has been an unfortunate perception, however, that overcapacity under *all* economic circumstances will result in increased cost pressure.

The assumption that overcapacity leads to increased prices in a competitive market economy has been joined by a second assumption: that use of the operating room in a single-specialty clinic for a relatively few hours per week is inefficient. Optimal capacity has not been defined for single- or multispecialty freestanding ambulatory care facilities. Nevertheless, HRPC staff has hitherto equated optimal hospital capacity with optimal office capacity.

A hospital operating room that is used only 13% of the time creates a gross economic inefficiency because its maintenance involves high overhead: nurses, anesthesiologists, and technicians must be on duty at all times and it must be available 24 hours a day. If it is not used, a great deal of money is lost. On the other hand, an office-based operating suite is used for elective procedures only and the physician can simply close it when patients are not scheduled for surgery. The doctor need not employ full-time nurses and anesthesiologists, and the only substantial wasted overhead would be the rent attributable to the unused suite (a relatively modest factor). If the suite does not make money, the physician can sell the equipment and close that portion of the office.

The cost of charity care. Payment for ambulatory surgery typically comprises two elements: the professional fees of the physician(s) performing the procedure and the fees of the facility providing the operating room and supplies. In Maryland, hospital facility fees are approved by the Health Services Cost Review Commission, but freestanding ambulatory facility fees are not subject to comprehensive regulation in non-hospital settings. According to the HRPC staff preliminary report, the result has been that "the level of payment for freestanding ambulatory surgery centers is thus based upon some combination of operating costs and perception of the appropriate market price for the services offered." The report also stated, "unlike in a hospital where a physician can only secure a professional fee for the services provided there, physicians who own interests in freestanding facilities...can secure some portion of the facility-fee revenues for themselves." Furthermore, the report stated:

> Rate regulation ensures that Maryland hospitals are reimbursed for charity cases and bad debt, so hospitals have always had a disproportionate share of uncompensated care. Freestanding ASC charges are not regulated, so there are no provisions for covering or distributing the costs of uncompensated care. Few ASCs are being established in the inner city areas or in areas with high underserved and underinsured populations. Because there is no adequate mechanism to reimburse the freestanding ASCs for uncompensated care, the uninsured and underinsured do not have equal access to all types of settings, causing an increasing financial burden for hospital rate structures. Thus the increasing number of operating rooms is creating more choice only for the well-insured population.

The foregoing statement, however, fails to take into account that under the Medicare waiver and under Medicaid generally, these governmental payers reimburse for hospital services at the all-payer rate. Thus, amounts paid to an ASC in facility fees by Medicare for services rendered outside the hospital are, at least to a layperson, an astonishingly smaller fraction of what is paid to a hospital for the same service by Medicare, and the difference between what Medicaid pays a private physician and a hospital is even greater than for Medicare. Neither the HRPC staff nor the newly-formed Governor's Task Force on Community Health Networks has tried to determine the extent to which these payments offset the "charity care" burden borne by the hospitals. Until this is done, no fair or reasonable analysis of the "uncompensated care" issue can be presented to the General Assembly for solution.

HRPC recommendations

The final report of the HRPC, *Ambulatory Surgery Services: Policy and Regulatory Issues*, presents a more balanced approach to the questions raised about the comparative values, advantages, and disadvantages presented by freestanding non-hospital and hospital ASCs and inpatient hospital surgical services. The final report recognizes the efficiency and high overall quality and patient friendliness of freestanding ambulatory care centers, as well as the essential nature of the hospital for the provision of emergency services, treatment of higher-risk and sicker patients, and provision of sophisticated services. The report also recognizes the need to address issues of patient access to quality care in all settings, but wisely calls for more study of the uncompensated care issue before any taxes are imposed on any sector of the market. The final report suggests replacing the ten single-specialty exemptions for ambulatory surgery with a single general exception for office facilities with one operating room that charge no facility fees and are not under contract with payers. Although the specifics of the recommendation regarding facility fees are unfair, and the suggestions regarding contracts with payers are unrealistic,

the *concept* behind the recommendations suggests there may be common ground where the disputants may meet. Nevertheless, the final report continues to assume that the HRPC has the authority to define *in regulations* which medical subspecialties may be regulated. Following the recommendation of the Governor's Task Force on Community Health Networks, the report suggests that only three of the subspecialties currently exempted from CON requirements should remain: ophthalmology, podiatry, and oral surgery. The suggestion, which is based on the misreading of the statutory language that led to creation of the "list of ten" in the first place, is a procedural controversy that should be settled before discussions of substance are addressed.

CON adjustments. One encouraging recommendation in the final report is that the CON process be adjusted to reflect modern market realities by removing the stringent geographical or jurisdictional analysis of need in determining whether a certificate will be granted and to develop an expedited review process for CON determination outside the Administrative Procedure Act. The report suggests that the General Assembly "change the CON statute to reflect the requirement that any proposed new ambulatory surgical facilities and proposed new ambulatory surgical capacity in or controlled by hospitals be subject to expedited CON review according to criteria developed by the Commission in regulation." If new criteria are fairly conceived and applied, the CON system may still be useful, at least to the extent that it is confined to regulation of the development of large, relatively expensive facilities.

Licensing. Much remains controversial in the final report. One seemingly innocuous recommendation (also drawn from the Governor's Task Force Report) is that all ASCs (except exempt office facilities) and gastrointestinal endoscopy facilities be licensed and that one condition of licensure be that these facilities accept Medicare and Medicaid patients. Many ambulatory facilities *do* accept these patients as a matter of course, but the hospitals rely on them particularly because, as noted above, Medicare and Medicaid pay hospital facility fees at the all-payer rate. If large numbers of these patients are diverted to freestanding ambulatory care facilities that are not hospital-based, the result will diminish the beneficial effect of the Medicare and Medicaid "waiver" that has helped to sustain Maryland hospitals.

The report assumes that in the future almost all health care will be provided in a managed care setting. Although managed care undoubtedly will become a major component of the health care economy, there are serious questions regarding managed care as it is administered today. Managed care should not be unfairly or unreasonably discouraged by the legislature and the regulatory bodies in Maryland, but it also should not be given an unfair advantage in the regulatory arena.

Interim solutions. The HRPC staff has suggested that its recommendations and suggestions are *interim* solutions pending the final evolution of our health system. If so, any proposed regulatory scheme should be modest for several reasons.

First, the concept of broad-based central economic planning is questionable. Planned economies tend not to thrive. The American economy is built primarily on a competitive model, and history has shown repeatedly that prolonged and pervasive regulatory interference eventually results in serious economic dislocation. One reason is that no planning agency, regardless of its sophistication, can accurately predict needs and resources.

Second, too much interference with the availability of services could diminish quality of care rather than improve it. In an unregulated market, patients will be drawn to the most efficient practitioners who provide high-quality care. Physicians who operate freestanding ambulatory surgical facilities in a competitive market can expect to lose their patients and their livelihoods if they fail to keep up with advances in technology, methodology, and quality of care. In a competitive economy, the fairest solution is to allow the market to decide who will provide the services.

Third, changes in the law should not be "grandfathered." Facilities with existing exemptions and CONs that continue to provide satisfactory services should not be at risk of losing their current status because existing law, upon which they relied in constructing and maintaining their facilities, has been changed out from under them.

Finally, a pervasive regulatory scheme could be expensive. The HRPC staff, apparently sensitive to such a risk, has recommended streamlining the CON process procedurally. Substantive streamlining might be a welcome change as well.

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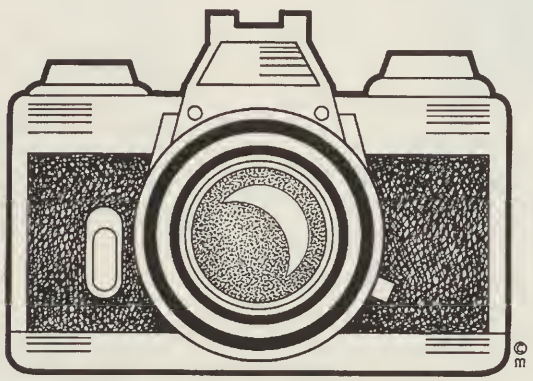
1. Md. Ann. Code, Health-General § 19-101 (e) (2) (v).
2. Code of Maryland Regulations, § 10.24.01.03G (1) (a). ■

Cellular telephones and other radio-frequency transmitting devices such as two-way radios may interfere with the functioning of electrical or electronic medical equipment. Canada's Medical Devices Bureau, which has conducted a study of the issue, reports that electromagnetic interference is unlikely unless the medical devices are within three meters of the transmitter (*Health Technology Trends* 1994;6(11):1,6).

Enter the Fifteenth Annual Med Chi PHOTO CONTEST!

Contest is open to all Med Chi and Alliance members.

Two categories: black & white OR color with first and second prizes awarded in each category.



Deadline for entries is Friday, March 17, 1995.

All entries will be displayed at the 1995 annual meeting at the Inn and Conference Center, College Park.

Photo Contest Rules:

Eligibility: All members of Med Chi and members of the Alliance may enter. Professional photographers may not enter.

1. Photographs may be submitted in two categories: black and white OR color.
2. Limit: three entries per person.
3. Prints only; prints smaller than 8" x 10" or larger than 11" x 14" will not be accepted. If your favorite shot is a slide, you must have a print made within this size range to enter the contest.
4. Entries must be matted or dry mounted. No framed photographs will be accepted.
5. Entries must have name, address, and telephone number attached to the back of each photograph.
6. Entries may be mailed or brought to Med Chi, 1211 Cathedral Street, Baltimore, MD 21201 by 5:00 pm on March 17.
7. Photographs entered in the contest will be on display at the 1995 annual meeting.
8. Prizes will be awarded to the first and second place winners in each category.
9. Winners will be announced at the annual meeting of the Medical and Chirurgical Faculty, May 4-6, 1995.
10. Photographs will not be mailed back. They may be claimed at the registration desk at the close of the annual meeting at noon on May 6 or at Med Chi thereafter.
11. Med Chi does not guarantee against loss or damage of any kind to the photographs submitted to the contest.

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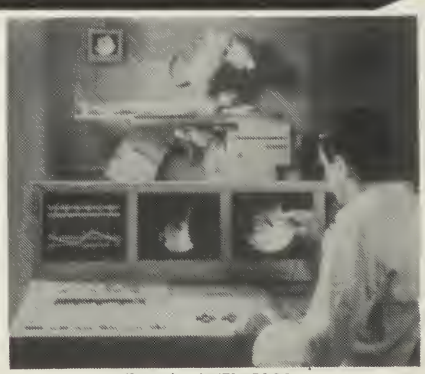
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Med Chi's 1995 Maryland state legislative directory

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Med Chi officers

- **Board of Trustees**

  President *Donald H. Dembo, M.D.*
  President-elect *J. Richard Lilly, M.D.*
  Immediate Past President *Joseph Snyder, M.D.*
  Secretary *Paul A. Stagg, M.D.*
  Treasurer *Carol W. Garvey, M.D.*
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  Trustee *Thomas E. Allen, M.D.*
  Speaker of the House *Allan D. Jensen, M.D.*
  Vice Speaker of the House *Louis C. Breschi, M.D.*
  Chairperson, Maryland Delegation to the AMA *George S. Malouf, Sr., M.D.*

- **Legislative Committee chairperson**

  Hilary T. O'Herlihy, M.D.

- **Med Chi staff**

  Chief Executive Officer *Angelo J. Troisi, F.A.C.H.E.*
  Chief Operating Officer *Roseanne M. Matricciani, R.N., J.D.*
  General Counsel *Angus Everton, Esq.*
  Legislative Assistant/Office Manager *Anna Marie Johnson*

- **Med Chi lobbyist**

  Joseph A. Schwartz, III, Esq.

FOR FURTHER INFORMATION, *contact the*
DEPARTMENT OF LEGISLATIVE REFERENCE

From the Baltimore area	841-3870
From the Washington area	858-3870
Elsewhere in Maryland	800-492-7122
	ext. 3870

The legislative process*

FROM HOPPER TO ENACTMENT

The drafting of legislation requires the skill of experienced and trained personnel. This service is rendered by the Department of Legislative Reference. A bill or joint resolution may be introduced in advance of regular sessions and is styled a "prefiled bill." A bill is filed (is dropped into the hopper) with the secretary of the Senate or the clerk of the House, is given a number, and is readied for its first reading on the floor. Bills may be introduced in either chamber until the last 35 days of the session. After that, bills may be introduced only with the consent of two-thirds of the membership.

First reading. The reading clerk, when the session has convened, reads the title, and the presiding officer assigns the bill to the appropriate committee.

Reference to committee. The committees meet daily during the session to receive testimony and take action on bills assigned. Citizens are encouraged to present their views on the subject matter by mail or by personal appearance. Legislative agents (lobbyists), representing organized interest groups, speak at these hearings, either to oppose or support the proposed legislation. The Department of Fiscal Services prepares a fiscal analysis for each bill, and these fiscal notes are considered during the committee deliberation.

Unfavorable committee action, which may mean legislative death, frequently requires as much, or more, committee discussion and time as favorable committee action, which sends the bill to the floor for a second reading and floor consideration.

Second reading and floor consideration. The bill is reported to the floor by the committee (favorably, unfavorably, or without recommendation, and with or without committee amendment). The bill is open to amendment from the floor, and the ultimate form of the bill must be determined on second reading. Committee action may be reversed, but this is infrequent.

Third reading. The bill must be printed for third reading with all amendments included in this final version. No amendments may be presented on third reading in the chamber of its origin, and the bill must be passed by a majority of the elected membership.

Second chamber. The procedure follows a pattern identical with that of the chamber in which the bill originated, except amendments may be proposed during third reading as well as second reading. If not amended in the second chamber, final passage may occur without reprinting.

* *Information provided by the Maryland Department of Legislative Reference.*

Consideration of bills*

CONSIDERATION OF BILLS ORIGINATING IN ONE CHAMBER AND AMENDED IN SECOND CHAMBER

If amended in the second chamber, the bill is returned to the chamber of origin, where a vote is taken on a motion to concur with or reject the amendments. If concurrence is voted, the bill itself is voted on as amended and action is complete. The bill is reprinted, or enrolled, to include the added amendments, before submitting it to the governor.

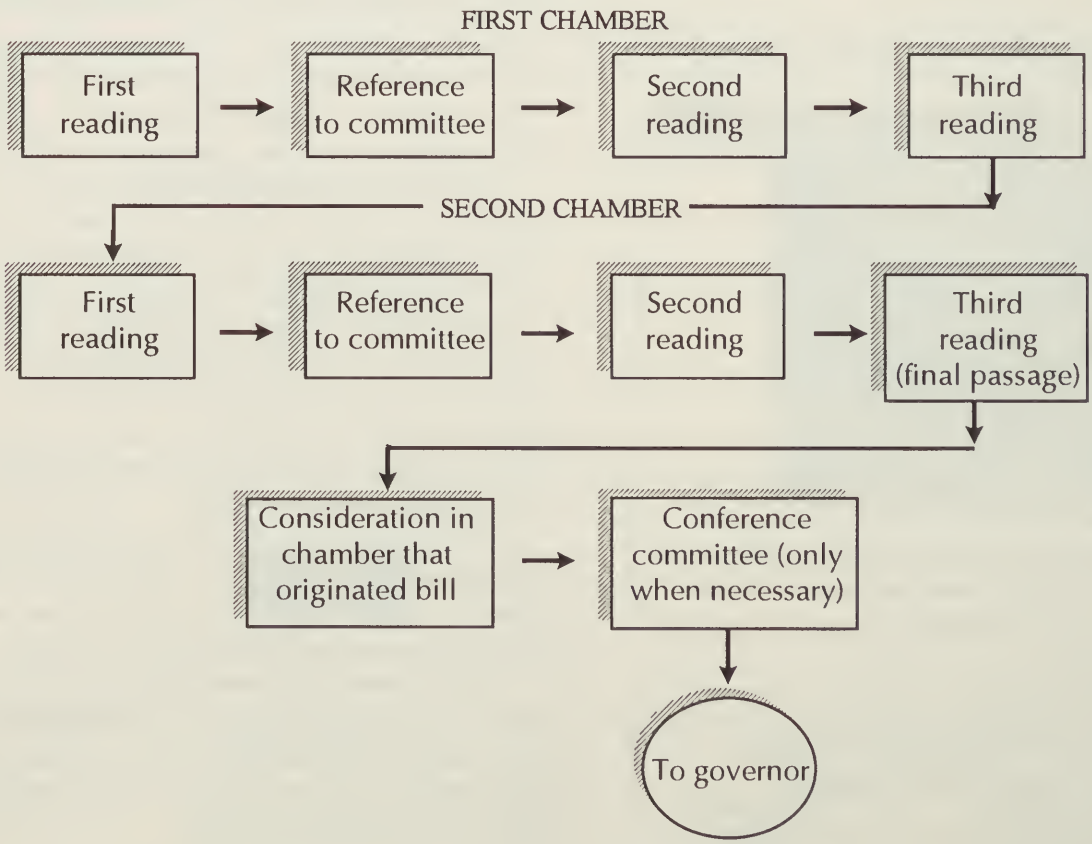
If the amendments are rejected, two courses of action are possible: 1) the amending chamber may be requested to withdraw its amendments, or 2) upon refusal of withdrawal of amendments, either chamber may request a conference committee to resolve the differences between the two chambers.

Conference committee. A report of a conference committee goes back to both chambers to be adopted or rejected without amendment. If the conference committee report is adopted, the bill is voted upon for final passage in each house. If the conference committee report is rejected by either house, the bill fails.

Presentation of bills to the governor. Presentation of all bills to the governor is mandatory, except for the budget bill and constitutional amendments. The budget bill becomes law upon its final passage and cannot be vetoed. Bills must be presented to the governor within 20 days following adjournment of a session, and in the case of such bills, the governor may veto them within 30 days after presentation to him or her. If a bill is not vetoed, it becomes a law. The governor may not veto a constitutional amendment.

The power to override a veto. This power rests with the legislature. If a bill is vetoed during regular session, the veto message is considered immediately. If a bill presented after the session is vetoed, the veto message must be considered at the next regular or special session of the legislature, except that the legislature may not override a veto during the first year of a new term. A three-fifths vote of the elected membership in each chamber is necessary to override a veto.

The progress of a bill*



** Information provided by the Maryland Department of Legislative Reference*

Important legislative dates

January 11 ..... General assembly convenes (noon, Wednesday).

January 18 ..... Inauguration of the Governor and Lt. Governor.

TBA ..... Governor delivers State of the State address.

TBA ..... Chief Judge delivers the State of the Judiciary Address.

TBA ..... Election of the State Treasurer.

January 20 ..... Final date for Governor to introduce Budget Bill. Final date for submission of executive orders reorganizing the executive branch of state government. (Either chamber may disapprove by resolution within 50 days. Administration bills introduced in the Senate after this date are referred to the Senate Rules Committee.)

January 24 ..... Senate bill and House bill request guarantee date.

January 30 ..... Final date for Governor to introduce capital budget bill.

February 3 ..... Senate and House bill introduction date. (Senate bills introduced after this date are referred to the Senate Rules Committee.) House bill introduction courtesy date.

February 19 ..... "Green Bag" appointments submitted by Governor--delivered on February 17.

February 24 ..... House bills introduced after this date are referred to the House Rules Committee.

March 6 ..... Final date for introduction of bills without suspension of rules.

March 21 ..... Committee reporting courtesy date. (Each chamber's committees should report out its own bills by this date.)

March 27 ..... Opposite chamber bill crossover date. (Each chamber should send to the other chamber those bills it intends to pass favorably. Opposite chamber bills received after this date are subject to referral to the rules committee.) Senate Rule 32 (c), House Courtesy Date.

April 3 ..... Budget bill to be passed by both chambers by this date.

April 10 ..... Adjournment "Sine die."

May 10 ..... Final date for an extended session.

Post-session

April 30 ..... Final date for presentment of bills to the governor.

May 30 ..... Governor to sign/veto bills by this date.

June 1 ..... Other than emergency bills, earliest date for bills to take effect.

July 1 ..... Budget, tax, and revenue bills to take effect.

October 1 ..... Usual effective date for bills.

Important telephone numbers

- Legislative information and library ..... ext. 3810
- Information desk, State House ..... ext. 3886
- President of Senate ..... ext. 3700 *Thomas V. 'Mike' Miller, Jr.*
- Senate majority leader ..... ext. 3697 *Clarence W. Blount*
- Senate minority leader ..... ext. 3568 *John A. Cade*
- Senate Budget and Taxation Committee ..... ext. 3690
- Senate Economic and Environmental Affairs Committee ..... ext. 3661
- Senate Finance Committee ..... ext. 3677
- Senate Judicial Proceedings Committee ..... ext. 3623
- Speaker of the House of Delegates ..... ext. 3800 *Casper R. Taylor, Jr.*
- House majority leader ..... ext. 3464 *John Adams Hurson*
- House minority leader ..... ext. 3401 *Robert H. Kittleman*
- House Committee on Appropriations ..... ext. 3407
- House Committee on Economic Matters ..... ext. 3519
- House Committee on Environmental Matters ..... ext. 3534
- House Judiciary Committee ..... ext. 3488
- House Committee on Ways and Means ..... ext. 3469
- Bill room (copies of bills, amendments, and fiscal notes) .... ext. 3840

Senate standing committees

Budget and Taxation

Room 100, Senate Office Building
Annapolis, MD 21401-1991
Telephone ext.—3690

- **Chairperson**
  Barbara A. Hoffman, Baltimore City (42)
- **Vice chairperson**
  William V. Amoss, Cecil and Howard counties (35)
- **Members**
  F. Vernon Boozer, Baltimore County (9)
  John A. Cade, Anne Arundel County (33)
  Ulysses Currie, Prince George's County (25)
  Patrick J. Hogan, Montgomery County (39)
  Edward J. Kasemeyer, Baltimore and Howard counties (12)
  Gloria Lawlah, Prince George's County (26)
  Nathaniel J. McFadden, Baltimore City (45)
  Thomas M. Middleton, Charles County (28)
  Donald F. Munson, Washington County (2)
  Ida G. Ruben, Montgomery County (20)
  Christopher Van Hollen, Montgomery County (18)

The Budget and Taxation Committee considers legislation that relates to state operating and capital budgets, including revenues and expenditures; supplementary appropriations; state and county bond authorizations; legislative budgetary procedures; taxation and assessments; education financing and pension or retirement matters.

Economic and Environmental Affairs

Room 200, Senate Office Building
Annapolis, MD 21401-1991
Telephone ext.—3661

- **Chairperson**
  Clarence W. Blount, Baltimore City (41)
- **Vice chairperson**
  Paula C. Hollinger, Baltimore County (11)
- **Members**
  Michael J. Collins, Baltimore County (6)
  David R. Craig, Harford County (34)
  Roy Dyson, Calvert and St. Mary's counties (29)
  Brian E. Frosh, Montgomery County (16)
  Christopher J. McCabe, Howard and Montgomery counties (14)
  Paul G. Pinsky, Prince George's County (22)
  Perry Sfikas, Baltimore City and Baltimore County (46)
  J. Lowell Stoltzfus, Somerset, Worcester and Wicomico counties (38)
  Leonard H. Teitelbaum, Montgomery County (19)

The Economic and Environmental Affairs Committee considers legislation that relates to licensing and regulation of businesses and labor; alcoholic beverages; natural resources; agriculture and land preservation; the environment; energy; election laws; veterans affairs; fire prevention; education programs; procurement; local and government affairs; and state and government organizations, procedures and administrative law.

This information is accurate as of press time. Please contact the Department of Legislative Reference, ext. 3810, for current information.

Finance

Presidential Wing, Senate Office Building
Annapolis, MD 21401-1991
Telephone ext.—3677

- **Chairperson**
  Thomas L. Bromwell, Baltimore County and Baltimore City (8)
- **Vice chairperson**
  Arthur Dorman, Prince George's County (21)
- **Members**
  John C. Astle, Anne Arundel County (30)
  George W. Della, Jr., Baltimore City (47)
  John W. Derr, Frederick and Washington counties (3)
  John J. Hafer, Allegany and Garrett counties (1)
  Martin G. Madden, Howard and Prince George's counties (13)
  John A. Pica, Jr., Baltimore City (43)
  Jean W. Roesser, Montgomery County (15)
  Decatur W. Trotter, Prince George's County (24)
  Larry Young, Baltimore City (44)

The Finance Committee considers legislation that relates to health and welfare matters; insurance; credit regulation and consumer financing; state personnel issues; economic and community development; social programs; worker's compensation; racing and lotteries; banking and financial institutions; transportation; unemployment insurance; labor and employment; and utility regulations.

Judicial Proceedings

Room 300, Senate Office Building
Annapolis, MD 21401-1991
Telephone ext.—3623

- **Chairperson**
  Walter M. Baker, Caroline, Cecil, Kent, Queen Anne's and Talbot counties (36)
- **Vice Chairperson**
  Leo E. Green, Prince George's County (23)
- **Members**
  Richard F. Colburn, Dorchester, Caroline, Talbot, and Wicomico counties (37)
  Timothy R. Ferguson, Frederick and Carroll counties (4)
  Jennie M. Forehand, Montgomery County (17)
  Larry E. Haines, Carroll County (5)
  Ralph M. Hughes, Baltimore City (40)
  Philip C. Jimeno, Anne Arundel County (31)
  Delores G. Kelley, Baltimore County and Baltimore City (10)
  C. Edward Middlebrooks, Anne Arundel County (32)
  Norman R. Stone, Jr., Baltimore County (7)

The Judicial Proceedings Committee considers legislation that relates to judicial administration and court structure; constitutional amendments; legal profession; criminal and civil laws, penalties, and procedures; legal rights and immunities; corrections; juvenile justice; family law; ethics; commercial code; real property; landlord/tenant laws; trusts and estates; public safety; law enforcement organizations; equal rights and opportunities; and vehicle laws.

Calling your representatives in Annapolis is a local call from the Baltimore and Washington areas. From the Baltimore area, dial the exchange 841; from the Washington area, dial the exchange 858; outside the Baltimore/Washington areas, dial 800-492-7122.

House standing committees

Appropriations

Room 131, House Office Building
Annapolis, MD 21401-1991
Telephone ext.—3407

- **Chairperson**
  Howard P. Rawlings, Baltimore City (40)
- **Vice chairperson**
  Norman H. Conway, Somerset, Worcester and Wicomico counties (38)
- **Members**
  Wheeler R. Baker, Kent, Queen Anne's, Cecil, Caroline, and Talbot counties (36)
  Robert C. Baldwin, Anne Arundel County (33)
  Talmadge Branch, Baltimore City (45)
  Joan Cadden, Anne Arundel County (31)
  Thomas E. Dewberry, Baltimore County (47B)
  Richard N. Dixon, Carroll County (5)
  George C. Edwards, Allegany and Garrett counties (1A)
  Robert L. Flanagan, Howard and Montgomery counties (14B)
  Peter Franchot, Montgomery County (20)
  Donald C. Fry, Harford County (35A)
  Sue Hecht, Washington and Frederick counties (3)
  Kenneth Holt, Baltimore County (6)
  Brenda B. Hughes, Prince Georges County (25)
  John Adams Hurson, Montgomery County (18)
  Martha S. Klima, Baltimore County (9A)
  Nancy K. Kopp, Montgomery County (16)
  Richard LaVay, Montgomery County (15)
  Maggie McIntosh, Baltimore City (42)
  Richard A. Palumbo, Prince George's County (22A)
  Joan N. Parker, Baltimore County (10)
  Joan B. Pitkin, Prince George's County(23)
  James E. Proctor, Jr., Prince George's County (27A)
  Samuel I. Rosenberg, Baltimore City (42)
  John Frank Slade, III, Calvert and St. Mary's counties (29B)
  Nancy R. Stocksdale, Carroll County (5)

The Appropriations Committee considers legislation that relates to state operating and capital budgets; supplementary appropriations bills; state and county bonds and loans; higher education; collective bargaining; fiscal procedures; medical assistance; social services; and state personnel and pension matters.

Commerce and Governmental Matters

Room 141, House Office Building
Annapolis, MD 21401-1991
Telephone ext.—3502

- **Chairperson**
  Gerald J. Curran, Baltimore City (43)
- **Vice chairperson**
  John F. Wood, Jr., Calvert and St. Mary's counties (29A)
- **Members**
  John S. Arnick, Baltimore County (7)
  Joanne C. Benson, Prince George's County (24)
  Elizabeth Bobo, Baltimore and Howard counties (12B)
  David R. Brinkley, Frederick and Carroll counties (4A)
  Virginia P. Clagett, Anne Arundel County (30)
  Mary A. Conroy, Prince George's County (23)
  Diane DeCarlo, Baltimore County (6)
  Cornell N. Dypski, Baltimore City (46)
  Patricia Anne Faulkner, Montgomery County(14A)
  Joseph M.Getty, Carroll County (5)
  Cheryl C. Kagan, Montgomery County (17)
  Robert H. Kittleman, Montgomery and Howard counties (14B)
  James E. Malone, Jr., Baltimore and Howard counties (12A)
  Adriene A. Mandel, Montgomery County (19)
  Joseph Minnick, Baltimore County (7)
  John S. Morgan, Howard and Prince George's counties (13B)
  Nathaniel T. Oaks, Baltimore City and Baltimore County (41)
  Obie Patterson, Prince George's County (26)
  D. Bruce Poole, Washington County (2B)
  David D. Rudolph, Harford and Cecil counties (35B)
  Louise V. Snodgrass, Washington and Frederick counties (3)

The Commerce and Governmental Matters Committee considers legislation that relates to banking; credit unions; savings and loans; ethics; minority business enterprises; election laws; procurement; local and governmental affairs; transportation and vehicle laws.

Economic Matters

Room 151, House Office Building
Annapolis, MD 21401-1991
Telephone ext.—3519

- **Chairperson**
  Michael Erin Busch, Anne Arundel County (30)
- **Vice chairperson**
  Michael R. Gordon, Montgomery County (17)
- **Members**
  Kumar P. Barve, Montgomery County (17)
  Frank D. Boston, Jr., Baltimore City and Baltimore County (41)
  Michael A. Crumlin, Prince George's County(25)
  Elijah E. Cummings, Baltimore City (44)
  John P. Donoghue, Washington County (2C)
  Adelaid C. Ekardt, Dorchester, Caroline, Talbot, and Wicomico counties (37B)
  Nathaniel Exum, Prince George's County (24)
  Robert L. Frank, Baltimore County (11)
  Marilyn Goldwater, Montgomery County (16)
  Hattie N. Harrison, Baltimore City (45)
  A. Wade Kach, Baltimore County (9A)
  James M. Kelly, Baltimore County (9B)
  Ruth M. Kirk, Baltimore City (44)
  Carolyn J. Krysiak, Baltimore City (46)
  Mary Ann Love, Anne Arundel County (32)
  Charles A. McClenahan, Somerset, Wicomico, and Worcester counties (38)
  Van T. Mitchell, Charles County (28)
  Matthew Mossburg, Montgomery County (39)
  Shane Pendergrass, Howard and Prince George's counties (13A)
  Victoria L. Schade, Anne Arundel County (31)
  Mary Roe Walkup, Kent, Queen Anne's, Cecil, Caroline, and Talbot counties (36)

The Economic Matters Committee considers legislation relating to licensing and regulation of businesses and labor; commercial law; labor and employment; economic development; insurance regulation; unemployment insurance; consumer protection; real estate and real property transactions; and alcoholic beverages.

Environmental Matters

Room 161, House Office Building
Annapolis, MD 21401-1991
Telephone ext.—3534

- **Chairperson**
  Ronald A. Guns, Caroline, Cecil, Kent, Queen Anne's, and Talbot counties (36)
- **Vice chairperson**
  Michael H. Weir, Baltimore and Harford counties (6)
- **Members**
  Leon G. Billings, Montgomery County (18)
  Barrie S. Ciliberti, Montgomery County (39)
  Dereck Davis, Prince George's County (25)
  Donald B. Elliott, Carroll and Howard counties (4)
  Barbara Frush, Prince George's County (21)
  Tony E. Fulton, Baltimore City (40)
  Peter A. Hammen, Baltimore City and Baltimore County (46)
  James W. Hubbard, Prince George's County (23)
  Don B. Hughes, Dorchester, Caroline, Talbot, and Wicomico counties (37A)
  Katherine Klausmeier, Baltimore County and Baltimore City (8)
  Brian K. McHale, Baltimore City (47A)
  Jacob J. Morhorovic, Jr., Baltimore County (7)
  Dan K. Morhaim, Baltimore County (11)
  Margaret H. Murphy, Baltimore City (41)
  Shirley Nathan-Pulliam, Baltimore County and Baltimore City (10)
  George W. Owings, III, Prince George's, Anne Arundel and Calvert counties (27B)
  Alfred W. Redmer, Jr., Baltimore County (8)
  Kenneth D. Schisler, Caroline, Dorchester, Talbot, and Wicomico counties (37B)
  Paul S. Stull, Frederick and Carroll counties (4A)
  J. Anita Stup, Frederick and Washington counties (3)

The Environmental Matters Committee considers legislation that relates to natural resources and the environment, including land use planning and zoning; health policy and planning; regulation of utilities governed by the Public Service Commission; and agriculture.

Calling your representatives in Annapolis is a local call from the Baltimore and Washington areas. From the Baltimore area, dial the exchange 841; from the Washington area, dial the exchange 858; outside the Baltimore/Washington areas, dial 800-492-7122.

Judiciary

Room 121, House Office Building
Annapolis, MD 21401-1991
Telephone ext.—3488

- **Chairperson**
  Joseph F. Vallario, Jr., Prince George's County (27A)
- **Vice chairperson**
  Ann Marie Doory, Baltimore City (43)
- **Members**
  Rushern L. Baker,III, Prince George's County (22B)
  Phillip D. Bissett, Anne Arundel County (30)
  Emmett C. Burns, Jr., Baltimore County and Baltimore City (10)
  Michael W. Burns, Anne Arundel County (32)
  Dana Lee Dembrow, Montgomery County (20)
  Gilbert J. Genn, Montgomery County (16)
  Sharon Grosfeld, Baltimore County and Baltimore City (18)
  James M. Harkins, Harford County (35A)
  Thomas E. Hutchins, Charles County (28)
  Nancy Jacobs, Harford County (34)
  Pauline H. Menes, Prince George's County (21)
  Kenneth C. Montague, Jr., Baltimore City (43)
  Donald E. Murphy, Baltimore and Howard counties (12A)
  Timothy D. Murphy, Baltimore City and Baltimore County (47A)
  Anthony J. O'Donnell, Calvert and St. Mary's counties (29)
  Marsha G. Perry, Anne Arundel County (33)
  Carol Stoker Petzold, Montgomery County (19)
  Mary Louise Preis, Harford County (34)
  Frank S. Turner, Howard and Prince George's counties (13A)
  David M. Valderrama, Prince George's County (26)

The Judiciary Committee considers legislation that relates to judicial administration and court structure; legal profession; criminal and civil laws and procedures; corrections; juvenile justice; family law; administrative law; trusts and estates; and drugged and drunk driving.

Ways and Means

Room 111, House Office Building
Annapolis, MD 21401-1991
Telephone ext.—3469

- **Chairperson**
  Sheila E. Hixson, Montgomery County (20)
- **Vice chairperson**
  James C. Rosapepe, Prince George's County (21)
- **Members**
  Raymond Beck, Montgomery County (39)
  Rose Mary Hatem Bonsack, Harford County (34)
  K. Bennett Bozman, Somerset, Worcester and Wicomico counties (38)
  James W. Campbell, Baltimore City (42)
  Jean Cryor, Montgomery County (15)
  Clarence Davis, Baltimore City (45)
  Michael J. Finifter, Baltimore County (11)
  Janet Greenip, Anne Arundel County (33)
  Anne Healey, Prince George's County (22A)
  Henry B. Heller, Montgomery County (19)
  Carolyn J.B. Howard, Prince George's County (24)
  John R. Leopold, Anne Arundel County (31)
  Samuel C. Linton, Charles County (28)
  Salima Siler Marriott, Baltimore City (40)
  Robert A. McKee, Washington County (2A)
  Clarence M. Mitchell, IV, Baltimore City (44)
  C. Anthony Muse, Prince George's County (26)
  James F. Ports, Jr., Baltimore County and Baltimore City (8)
  James E. Rzepkowski, Anne Arundel County (32)
  Mark K. Shriver, Montgomery County (15)
  Betty Workman, Allegany County (1B)

The Ways and Means Committee considers legislation that relates to state and local taxation, including property tax credit programs and assessments; education financing; primary and secondary education programs; funding of health, welfare and transportation programs; lottery and horse racing.

This information is accurate as of press time. Please contact the Department of Legislative Reference, ext. 3810, for current information.

1995 Maryland General Assembly, by Legislative District

LEGISLATIVE DISTRICT 1
Garrett and Allegany counties
- Sen. John J. Hafer
- Del. George C. Edwards (1A)
- Del. Betty Workman (1B)
- Del. Casper Taylor, Jr. (1C)

LEGISLATIVE DISTRICT 2
Washington County
- Sen. Donald F. Munson
- Del. Robert A. McKee (2A)
- Del. D. Bruce Poole (2B)
- Del. John P. Donoghue (2C)

LEGISLATIVE DISTRICT 3
Washington and Frederick counties
- Sen. John W. Derr
- Del. Sue Hecht
- Del. Louise V. Snodgrass
- Del. J. Anita Stup

LEGISLATIVE DISTRICT 4
Frederick and Carroll counties
- Sen. Timothy R. Ferguson
- Del. David R. Brinkley (4A)
- Del. Paul S. Stull (4A)
- Del. Donald B. Elliott (4B)

LEGISLATIVE DISTRICT 5
Carroll County
- Sen. Larry E. Haines
- Del. Richard N. Dixon
- Del. Joseph M. Getty
- Del. Nancy R. Stocksdale

LEGISLATIVE DISTRICT 6
Baltimore and Harford counties
- Sen. Michael J. Collins
- Del. Diane DeCarlo
- Del. Kenneth Holt
- Del. Michael H. Weir

LEGISLATIVE DISTRICT 7
Baltimore County
- Sen. Norman R. Stone, Jr.
- Del. John S. Arnick
- Del. Joseph Minnick
- Del. Jacob J. Mohorovic, Jr.

LEGISLATIVE DISTRICT 8
Baltimore County and Baltimore City
- Sen. Thomas L. Bromwell
- Del. Katherine Klausmeier
- Del. James F. Ports, Jr.
- Del. Alfred W. Redmer, Jr.

LEGISLATIVE DISTRICT 9
Baltimore County
- Sen. F. Vernon Boozer
- Del. A. Wade Kach (9A)
- Del. Martha S. Klima (9A)
- Del. James M. Kelly (9B)

LEGISLATIVE DISTRICT 10
Baltimore County and Baltimore City
- Sen. Delores G. Kelley
- Del. Emmett C. Burns, Jr.
- Del. Shirley Nathan-Pulliam
- Del. Joan N. Parker

LEGISLATIVE DISTRICT 11
Baltimore County
- Sen. Paula C. Hollinger
- Del. Michael J. Finifter
- Del. Robert L. Frank
- Del. Dan K. Morhaim

LEGISLATIVE DISTRICT 12
Baltimore and Howard counties
- Sen. Edward J. Kasemeyer
- Del. James E. Malone, Jr. (12A)
- Del. Donald E. Murphy (12 A)
- Del. Elizabeth Bobo (12 B)

LEGISLATIVE DISTRICT 13
Howard and Prince George's counties
- Sen. Martin G. Madden
- Del. Shane Pendergrass (13A)
- Del. Frank S. Turner (13A)
- Del. John S. Morgan (13B)

LEGISLATIVE DISTRICT 14
Montgomery and Howard counties
- Sen. Christopher J. McCabe
- Del. Patricia Anne Faulkner (14A)
- Del. Robert L. Flanagan (14B)
- Del. Robert H. Kittleman (14B)

LEGISLATIVE DISTRICT 15
Montgomery County
- Sen. Jean W. Roesser
- Del. Jean Cryor
- Del. Richard LaVay
- Del. Mark K. Shriver

LEGISLATIVE DISTRICT 16
Montgomery County
- Sen. Brian E. Frosh
- Del. Gilbert J. Genn
- Del. Marilyn Goldwater
- Del. Nancy K. Kopp

LEGISLATIVE DISTRICT 17
Montgomery County
- Sen. Jennie Forehand
- Del. Kumar Barve
- Del. Michael R. Gordon
- Del. Cheryl C. Kagan

LEGISLATIVE DISTRICT 18
Montgomery County
- Sen. Christopher Van Hollen, Jr.
- Del. Leon G. Billings
- Del. Sharon Grosfeld
- Del. John Adams Hurson

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LEGISLATIVE DISTRICT 19
Montgomery County
Sen. Leonard H. Teitelbaum
Del. Henry B. Heller
Del. Adriene A. Mandel
Del. Carol Stoker Petzold

LEGISLATIVE DISTRICT 20
Montgomery County
Sen. Ida G. Ruben
Del. Dana Lee Dembrow
Del. Peter Franchot
Del. Sheila Ellis Hixson

LEGISLATIVE DISTRICT 21
Prince George's County
Sen. Arthur Dorman
Del. Barbara Frush
Del. Pauline H. Menes
Del. James C. Rosapepe

LEGISLATIVE DISTRICT 22
Prince George's County
Sen. Paul G. Pinsky
Del. Anne Healey (22A)
Del. Richard A. Palumbo (22A)
Del. Rushern L. Baker, III (22B)

LEGISLATIVE DISTRICT 23
Prince George's County
Sen. Leo E. Green
Del. Mary A. Conroy
Del. James W. Hubbard
Del. Joan B. Pitkin

LEGISLATIVE DISTRICT 24
Prince George's County
Sen. Decatur W. Trotter
Del. Joanne C. Benson
Del. Nathaniel Exum
Del. Carolyn J.B. Howard

LEGISLATIVE DISTRICT 25
Prince George's County
Sen. Ulysses Currie
Del. Michael A. Crumlin
Del. Dereck Davis
Del. Brenda B. Hughes

LEGISLATIVE DISTRICT 26
Prince George's County
Sen. Gloria Gary Lawlah
Del. C. Anthony Muse
Del. Obie Patterson
Del. David M. Valderrama

LEGISLATIVE DISTRICT 27
Prince George's, Calvert, and Anne Arundel counties
Sen. Thomas V. 'Mike' Miller, Jr.
Del. James E. Proctor, Jr. (27A)
Del. Joseph F. Vallario, Jr. (27A)
Del. George W. Owings, III (27B)

LEGISLATIVE DISTRICT 28
Charles County
Sen. Thomas McLain Middleton
Del. Thomas E. Hutchins
Del. Samuel C. Linton
Del. Van T. Mitchell

LEGISLATIVE DISTRICT 29
Calvert and St. Mary's counties
Sen. Roy Dyson
Del. John F. Wood, Jr. (29A)
Del. John Frank Slade, III (29B)
Del. Anthony J. O'Donnell

LEGISLATIVE DISTRICT 30
Anne Arundel County
Sen. John C. Astle
Del. Phillip D. Bissett
Del. Michael Erin Busch
Del. Virginia P. Clagett

LEGISLATIVE DISTRICT 31
Anne Arundel County
Sen. Philip C. Jimeno
Del. Joan Cadden
Del. John R. Leopold
Del. Victoria L. Schade

LEGISLATIVE DISTRICT 32
Anne Arundel County
Sen. C. Edward Middlebrooks
Del. Michael W. Burns
Del. Mary Ann Love
Del. James E. Rzepkowski

LEGISLATIVE DISTRICT 33
Anne Arundel County
Sen. John A. Cade
Del. Robert C. Baldwin
Del. Janet Greenip
Del. Marsha G. Perry

LEGISLATIVE DISTRICT 34
Harford County
Sen. David R. Craig
Del. Rose Mary Hatem Bonsack
Del. Nancy Jacobs
Del. Mary Louise Preis

LEGISLATIVE DISTRICT 35
Harford and Cecil counties
Sen. William H. Amoss
Del. Donald C. Fry (35A)
Del. James M. Harkins (35A)
Del. David D. Rudolph (35B)

LEGISLATIVE DISTRICT 36
Kent, Queen Anne's, Cecil, Caroline, and Talbot counties
Sen. Walter M. Baker
Del. Wheeler R. Baker
Del. Ronald A. Guns
Del. Mary Roe Walkup

LEGISLATIVE DISTRICT 37
Dorchester, Caroline, Talbot, and Wicomico counties
Sen. Richard Colburn
Del. Don B. Hughes (37A)
Del. Adelaid C. Ekardt (37B)
Del. Kenneth D. Schisler (37B)

This information is accurate as of press time. Please contact the Department of Legislative Reference, ext. 3810, for current information.

LEGISLATIVE DISTRICT 38

Somerset, Worcester, and Wicomico counties

Sen. J. Lowell Stoltzfus
Del. K. Bennett Bozman
Del. Norman H. Conway
Del. Charles A. McClenahan

LEGISLATIVE DISTRICT 39

Montgomery County

Sen. Patrick J. Hogan
Del. Raymond Beck
Del. Barrie S. Ciliberti
Del. Mathew Mossburg

LEGISLATIVE DISTRICT 40

Baltimore City

Sen. Ralph M. Hughes
Del. Tony E. Fulton
Del. Salima Siler Marriott
Del. Howard P. Rawlings

LEGISLATIVE DISTRICT 41

Baltimore City and Baltimore County

Sen. Clarence W. Blount
Del. Frank D. Boston, Jr.
Del. Margaret H. Murphy
Del. Nathaniel T. Oaks

LEGISLATIVE DISTRICT 42

Baltimore City

Sen. Barbara A. Hoffman
Del. James W. Campbell
Del. Maggie McIntosh
Del. Samuel I. Rosenberg

LEGISLATIVE DISTRICT 43

Baltimore City

Sen. John A. Pica, Jr.
Del. Gerald J. Curran
Del. Ann Marie Doory
Del. Kenneth Charles Montague, Jr.

LEGISLATIVE DISTRICT 44

Baltimore City

Sen. Larry Young
Del. Elijah E. Cummings
Del. Ruth M. Kirk
Del. Clarence M. Mitchell, IV

LEGISLATIVE DISTRICT 45

Baltimore City

Sen. Nathaniel McFadden
Del. Talmadge Branch
Del. Clarence Davis
Del. Hattie N. Harrison

LEGISLATIVE DISTRICT 46

Baltimore City and Baltimore County

Sen. Perry Sfikas
Del. Cornell N. Dypski
Del. Peter A. Hammen
Del. Carolyn J. Krysiak

LEGISLATIVE DISTRICT 47

Baltimore City and Baltimore County

Sen. George W. Della, Jr.
Del. Brian K. McHale (47A)
Del. Timothy D. Murphy (47A)
Del. Thomas E. Dewberry (47B)

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Members of the Senate, alphabetically with addresses

♦ **Amoss, William H.** *(Dist. 35)*
Session ..... 100 Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3603
District ..... 2303 Bel Air Rd.
address ..... P.O. Box 496
Fallston 21047-0496
410-838-7555
410-879-7272
Member
since ..... 1983 (House 1975-1982)

♦ **Astle, John C.** *(Dist. 30)*
Session ..... PW Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3578
District ..... PW Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3578
Member
since ..... 1995 (House 1983-1994)

♦ **Baker, Walter M.** *(Dist. 36)*
Session ..... 301 Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3639
District ..... 153 East Main St.
address ..... Elkton 21921-5975
410-398-0980
Member
since 1979

♦ **Blount, Clarence W.** *(Dist. 41)*
Session ..... 201 Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3697
District ..... 4811 Liberty Hghts. Ave.
address ..... Baltimore 21207-7193
410-466-1197
Member
since 1971

♦ **Boozer, F. Vernon** *(Dist. 9)*
Session ..... 410 Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3706
District ..... 614 Bosley Ave.
address ..... Towson 21204-4066
410-828-0669
Member
since ..... 1981 (House 1971-1979)

♦ **Bromwell, Thomas L.** *(Dist. 8)*
Session ..... PW Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3620
District ..... PW Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3620
Member
since ..... 1983 (House 1979-1983)

♦ **Cade, John A.** *(Dist. 33)*
Session ..... 407 Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3568
District ..... 407 Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3568
Member
since 1975

♦ **Colburn, Richard** *(Dist. 37)*
Session ..... 311 Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3590
District ..... 311 Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3590
Member
since 1995

♦ **Collins, Michael J.** *(Dist. 6)*
Session ..... 216 Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3642
District ..... 418 Eastern Blvd.
address ..... Baltimore 21221-6786
410-391-7800
Member
since ..... 1986 (House 1978-1986)

♦ **Craig, David R.** *(Dist. 34)*
Session ..... 307 Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3158
District ..... 211 N. Washington St.
address ..... Havre de Grace 21078
410-273-6667
Member
since ..... 1995 (House 1991-1994)

♦ **Currie, Ulysses .** *(Dist. 25)*
Session ..... 100 Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3127
District ..... 100 Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3127
Member
since ..... 1995 (House 1987-1994)

♦ **Della, George W., Jr.** *(Dist. 47)*
Session ..... 207 Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3600
District ..... 801 Light St., 2nd Fl.
address ..... Baltimore 21230-3912
410-224-8400
Member
since 1983

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MEMBERS OF THE SENATE

♦ **Derr, John W.** *(Dist. 3)*
Session ..... 408 Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3575
District ..... 233 N. Market St.
address ..... Frederick 21701-5334
301-695-5733
Member
since 1983

♦ **Dorman, Arthur** *(Dist. 21)*
Session ..... 116 Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3141
District ..... 116 Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3141
Member
since ..... 1975 (House 1965-1975)

♦ **Dyson, Roy P.** *(Dist. 29)*
Session ..... 215 Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3673
District ..... 215 Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3673
Member
since 1995
(formerly U.S. Congress)

♦ **Ferguson, Timothy R.** *(Dist. 4)*
Session ..... 403 Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3704
District ..... 403 Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3704
Member
since 1995

♦ **Forehand, Jennie M.** *(Dist. 17)*
Session ..... 214 Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3134
District ..... 214 Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3134
Member
since ..... 1995 (House 1978-1994)

♦ **Frosh, Brian E.** *(Dist. 16)*
Session ..... 202 Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3124
District ..... 7315 Wisconsin Ave.
address ..... Suite 800 West
Bethesda 20814-3202
301-469-3179
Member
since ..... 1995 (House 1987-1994)

♦ **Green, Leo E.** *(Dist. 23)*
Session ..... 212 Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3631
District ..... 3123 Belair Dr.
address ..... Bowie 20715-3198
301-262-4420
Member
since ..... 1983 (House 1975-1979)

♦ **Hafer, John J.** *(Dist. 1)*
Session ..... 406 Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3565
District ..... 58 Frost Ave.
address ..... P.O. Box 116
Frostburg 21532-0116
301-689-4666
Member
since 1991

♦ **Haines, Larry E.** *(Dist. 5)*
Session ..... 401 Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3683
District ..... 532 Baltimore Blvd.
address ..... Westminster 21157
410-876-4530
Member
since 1991

♦ **Hoffman, Barbara A.** *(Dist. 42)*
Session ..... 100 Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3648
District ..... 6615 Reisterstown Rd.
address ..... Suite 301
Baltimore 21215-2603
410-764-3614
Member
since 1983

♦ **Hogan, Patrick J.** *(Dist. 39)*
Session ..... 305 Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3686
District ..... 305 Senate Office Bldg
address ..... Annapolis 21401-1991
ext. 3686
Member
since 1995

♦ **Hollinger, Paula C.** *(Dist. 11)*
Session ..... 206 Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3131
District ..... 206 Senate Office Bldg.
address ..... Annapolis 21401-1991
ext. 3131
Member
since ..... 1987 (House 1979-1987)

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♦ **Hughes, Ralph M.** *(Dist. 40)*
Session ..... 310 Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3656
District ..... 2320 North Monroe St.
address..... Baltimore 21217-1398
410-225-0555
Member
since..... 1991 (House 1983-1990)

♦ **Jimeno, Philip C.** *(Dist. 31)*
Session ..... 316 Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3658
District ..... 5915 Manor House Lane
address..... Baltimore 21225-3359
410-636-4134
Member
since..... 1985 (House 1979-1985)

♦ **Kasemeyer, Edward J.** *(Dist. 12)*
Session ..... 309 Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3653
District ..... 309 Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3653
Member
since..... 1995

♦ **Kelley, Delores G.** *(Dist. 10)*
Session ..... 209 Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3606
District ..... 209 Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3606
Member
since..... 1995

♦ **Lawlah, Gloria Gary** *(Dist. 26)*
Session ..... 314 Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3092
District ..... Rivertowne Commons
address..... 6133 Oxon Hill Rd.
Oxon Hill 20745-3108
301-839-0868
Member
since..... 1991 (House 1987-1990)

♦ **Madden, Martin G.** *(Dist. 13)*
Session ..... 402B Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3572
District ..... 402B Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3572
Member
since..... 1995 (House 1991-1994)

♦ **McCabe, Christopher J.** *(Dist. 14)*
Session ..... 404 Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3671
District ..... 12400 Clarksville Pike
address..... Clarksville 21029-1225
410-988-9818
Member
since..... 1991

♦ **McFadden, Nathaniel J.** *(Dist. 45)*
Session ..... 208 Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3165
District ..... 208 Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3165
Member
since..... 1995

♦ **Middlebrooks, C. Edward** *(Dist. 32)*
Session ..... 302 Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3593
District ..... 302 Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3593
Member
since..... 1995

♦ **Middleton, Thomas McLain** *(Dist. 28)*
Session ..... 210 Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3616
District 210 Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3616
Member
since..... 1995

♦ **Miller, Thomas V. 'Mike,' Jr.** *(Dist. 27)*
Session ..... H-107 State House
address..... Annapolis 21401-1991
ext. 3700
District ..... 8808 Old Branch Ave.
address..... P.O. Box 219
Clinton, MD 20735
Member
since..... 1975 (House 1971-1975)

♦ **Munson, Donald F.** *(Dist. 2)*
Session ..... 405 Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3609
District ..... 28 West Church St.
address..... Hagerstown 21740-4808
301-791-4511
Member
since..... 1991 (House 1975-1990)

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MEMBERS OF THE SENATE

♦ **Pica, John A., Jr.** *(Dist. 43)*
Session ..... 402A Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3145
District ..... 402A Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3145
Member
since..... 1983 (House 1979-1982)

♦ **Pinsky, Paul G.** *(Dist. 22)*
Session ..... 303 Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3155
District ..... 303 Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3155
Member
since..... 1995 (House 1987-1994)

♦ **Roesser, Jean W.** *(Dist. 15)*
Session ..... 308 Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3169
District ..... 308 Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3169
Member
since..... 1995 (House 1987-1994)

♦ **Ruben, Ida G.** *(Dist. 20)*
Session ..... 204 Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3634
District ..... 204 Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3634
Member
since..... 1987 (House 1975-1987)

♦ **Sfikas, Perry** *(Dist. 46)*
Session ..... 211 Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3598
District ..... 211 Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3598
Member
since..... 1995

♦ **Stoltzfus, J. Lowell** *(Dist. 38)*
Session ..... 409 Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3645
District ..... 30487 Broad St.
address..... Princess Anne 21853-1211
410-651-3886
410-742-3999
Member
since..... 1992 (House 1991-1992)

♦ **Stone, Norman R., Jr.** *(Dist. 7)*
Session ..... PW Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3587
District ..... 6905 Dunmanway
address..... Baltimore 21222-5194
410-288-5270
Member
since..... 1967 (House 1963 -1967)

♦ **Teitelbaum, Leonard H.** *(Dist. 19)*
Session ..... 205 Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3151
District ..... 205 Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3151
Member
since..... 1995 (House 1987-1994)

♦ **Trotter, Decatur W.** *(Dist. 24)*
Session ..... 313 Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3148
District ..... 1891 Brightseat Rd.
address..... Landover 20785-4256
301-772-2800
Member
since..... 1983 (House 1975-1979)

♦ **VanHollen, Christopher, Jr.** *(Dist. 18)*
Session ..... 304 Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3137
District ..... 304 Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3137
Member
since..... 1995 (House 1991-1994)

♦ **Young, Larry** *(Dist. 44)*
Session ..... 306 Senate Office Bldg.
address..... Annapolis 21401-1991
ext. 3612
District ..... 1716 McCulloh St.
address..... Baltimore 21217-3434
410-841-3612
Member
since..... 1988 (House 1975-1987)

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Members of the House, alphabetically with addresses

- **Arnick, John S.** *(Dist. 7)*
  Session ..... 426 House Office Bldg.
  address ..... Annapolis 21401-1991
  ext. 3458
  District ..... 7918 Diehlwood Rd.
  address ..... Dundalk 21222-3316
  410-285-2109
  Member
  since 1983 (1967-1979)

- **Baker, Rushern L., III** *(Dist. 22B)*
  Session ..... 207 House Office Bldg.
  address ..... Annapolis 21401-1991
  ext. 3058
  District ..... 207 House Office Bldg.
  address ..... Annapolis 21401-1991
  ext. 3058
  Member
  since 1995

- **Baker, Wheeler R.** *(Dist. 36)*
  Session ..... 422 House Office Bldg.
  address ..... Annapolis 21401-1991
  ext. 3189
  District ..... 422 House Office Bldg.
  address ..... Annapolis 21401-1991
  ext. 3189
  Member
  since 1995

- **Baldwin, Robert C.** *(Dist. 33)*
  Session ..... 214 House Office Bldg.
  address ..... Annapolis 21401-1991
  ext. 3223
  District ..... 214 House Office Bldg.
  address ..... Annapolis 21401-1991
  ..... ext. 3223
  Member
  since 1995

- **Barve, Kumar P.** *(Dist. 17)*
  Session ..... 222 House Office Bldg.
  address ..... Annapolis 21401-1991
  ext. 3001
  District ..... 11 Pontiac Way
  address ..... Gaithersburg 20878-2743
  301-869-1488
  Member
  since 1991

- **Beck, Raymond** *(Dist. 39)*
  Session ..... 225 House Office Bldg.
  address ..... Annapolis 21401-1991
  ext. 3037
  District ..... 225 House Office Bldg.
  address ..... Annapolis 21401-1991
  ext. 3037
  Member
  since 1995

- **Benson, Joanne C.** *(Dist. 24)*
  Session ..... 204 House Office Bldg.
  address ..... Annapolis 21401-1991
  ext. 3065
  District ..... 1891 Brightseat Rd.
  address ..... Landover 20785-4256
  301-772-2802
  Member
  since 1991

- **Billings, Leon G.** *(Dist. 18)*
  Session ..... 223 House Office Bldg.
  address ..... Annapolis 21401-1991
  ext. 3028
  District ..... 3940 Rickover Rd.
  address ..... Silver Spring 20902-2329
  301-946-5916
  Member
  since 1991

- **Bissett, Phillip D.** *(Dist. 30)*
  Session ..... 212 House Office Bldg.
  address ..... Annapolis 21401-1991
  ext. 3211
  District ..... 212 House Office Bldg.
  address ..... Annapolis 21401-1991
  ext. 3211
  Member
  since 1991

- **Bobo, Elizabeth** *(Dist. 12B)*
  Session ..... 209 House Office Bldg.
  address ..... Annapolis 21401-1991
  ext. 3205
  District ..... 209 House Office Bldg.
  address ..... Annapolis 21401-1991
  ext. 3205
  Member
  since 1995

- **Bonsack, Rose Mary Hatem** *(Dist. 34)*
  Session ..... 326 House Office Bldg.
  address ..... Annapolis 21401-1991
  ext. 3289
  District ..... 118 West Bel Air Ave.
  address ..... Aberdeen 21001-3238
  410-273-9549
  Member
  since 1991

- **Boston, Frank D., Jr.** *(Dist. 41)*
  Session ..... 314 House Office Bldg.
  address ..... Annapolis 21401-1991
  ext. 3283
  District ..... 2200 Garrison Blvd.
  address ..... Suite 202
  Baltimore 21216-2631
  410-566-3373
  Member
  since 1987

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MEMBERS OF THE HOUSE

♦ **Bozman, Bennett** *(Dist. 38)*
Session ..... 413 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3431
District ..... 103 Cedar Ave.
address..... Berlin 21811-1138
410-641-2221
Member
since..... 1991

♦ **Branch, Talmadge** *(Dist. 45)*
Session ..... 301 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3257
District ..... 301 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3257
Member
since..... 1995

♦ **Brinkley, David R.** *(Dist. 4A)*
Session ..... 323 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3107
District ..... 323 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3107
Member
since..... 1995

♦ **Burns, Emmett C., Jr.** *(Dist. 10)*
Session ..... 309 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3350
District ..... 309 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3350
Member
since..... 1995

♦ **Burns, Michael W.** *(Dist. 32)*
Session ..... 215 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3233
District ..... 215 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3233
Member
since..... 1995

♦ **Busch, Michael Erin** *(Dist. 30)*
Session ..... 151 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3519
District ..... 151 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3519
Member
since..... 1987

♦ **Cadden, Joan** *(Dist. 31)*
Session ..... 213 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3217
District ..... 111 Cedar Hill Rd.
address..... Brooklyn Park 21225-3903
410-789-1914
Member
since..... 1991

♦ **Campbell, James W.** *(Dist.42)*
Session ..... 319 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3297
District ..... 1329 1/2 W 41st St.
address..... Baltimore 21211-1550
..... 410-366-8160
Member
since..... 1979

♦ **Ciliberti, Barrie S.** *(Dist. 39)*
Session ..... 225 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3037
District ..... 225 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3037
Member
since..... 1995

♦ **Clagett, Virginia** *(Dist. 30)*
Session ..... 212 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3211
District ..... 212 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3211
Member
since..... 1995

♦ **Conroy, Mary A.** *(Dist. 23)*
Session ..... 208 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3098
District ..... 208 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3098
Member
since..... 1986 (Senate 1982-1983)

♦ **Conway, Norman H.** *(Dist. 38)*
Session ..... 416 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3425
District ..... 1312 Whittier Dr.
address..... Salisbury 21801-3241
410-543-9060
Member
since..... 1987

Calling your representatives in Annapolis is a local call from the Baltimore and Washington areas. From the Baltimore area, dial the exchange 841; from the Washington area, dial the exchange 858; outside the Baltimore/Washington areas, dial 800-492-7122.

♦ **Crumlin, Michael A.** *(Dist. 25)*
Session ..... 203 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3076
District ..... 203 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3076
Member
since 1995

♦ **Cryor, Jean** *(Dist. 15)*
Session ..... 219 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3052
District ..... 219 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3052
Member
since 1995

♦ **Cummings, Elijah E.** *(Dist. 44)*
Session ..... 312 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3391
District ..... 2300 N. Calvert St.
address Ste.100
Baltimore 21218-5201
410-366-7212
Member
since 1983

♦ **Curran, Gerald J.** *(Dist. 43)*
Session ..... 141 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3502
District ..... Cromwell Ctr.
address ..... Suite 201
810 Gleneagles Ct.
Towson 21286-2203
410-821-2920
Member
since 1967

♦ **Davis, Clarence** *(Dist. 45)*
Session ..... 301 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3257
District ..... P.O. Box 33167
address ..... Baltimore 21218
410-366-0483
Member
since 1983

♦ **Davis, Dereck** *(Dist. 25)*
Session ..... 203 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3076
District 203 House Office Bldg.
address Annapolis 21401-1991
ext. 3076
Member
since 1995

♦ **DeCarlo, Diane** *(Dist. 6)*
Session ..... 303 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3384
District ..... 303 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3384
Member
since 1995

♦ **Dembrow, Dana Lee** *(Dist. 20)*
Session ..... 219 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3052
District ..... 10111 Colesville Rd.
address ..... Suite 117
Silver Spring 20901-2427
301-593-5359
Member
since 1987

♦ **Dewberry, Thomas E.** *(Dist. 47B)*
Session ..... 304 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3378
District ..... 1 Newburg Ave.
address ..... Baltimore 21228
410-747-0407
Member
since 1989

♦ **Dixon, Richard N.** *(Dist. 5)*
Session ..... 322 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3371
District ..... 1224 Western Chapel Rd.
address ..... New Windsor 21776-6945
410-848-6945
Member
since 1983

♦ **Donoghue, John P.** *(Dist. 2C)*
Session ..... 321 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3447
District ..... 49 Summit Ave.
address ..... Hagerstown 21740-5522
301-790-3780
Member
since 1991

♦ **Doory, Ann Marie** *(Dist. 43)*
Session ..... 121 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3476
District ..... 112 Taplow Rd.
address ..... Baltimore 21212-3312
410-323-0401
Member
since 1987

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♦ **Dypski, Cornell N.** *(Dist. 46)*
Session ..... 316 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3303
District ..... 638 South Decker Ave.
address ..... Baltimore 21224-3911
410-276-1974
Member
since ..... 1987 (Senate 1975-1983)

♦ **Eckardt, Adelaide C.** *(Dist. 37B)*
Session ..... 404 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3343
District ..... 404 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3343
Member
since 1995

♦ **Edwards, George C.** *(Dist. 1A)*
Session ..... 320 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3435
District ..... 23 N. Pennsylvania Ave.
address ..... P.O. Box 8
Grantsville 21536-0008
301-895-5720
Member
since 1983

♦ **Elliott, Donald B.** *(Dist. 4B)*
Session ..... 323 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3107
District ..... 204 Lambert Ave.
address ..... P.O. Box 370
New Windsor 21776-0370
410-848-5373
Member
since 1987

♦ **Exum, Nathaniel** *(Dist. 24)*
Session ..... 201 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3074
District ..... 1891 Brightseat Rd.
address ..... Landover 20785-4256
301-772-2801
Member
since 1975

♦ **Faulkner, Patricia A.** *(Dist. 14A)*
Session ..... 219 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3052
District ..... 219 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3052
Member
since 1995

♦ **Finifter, Michael J.** *(Dist. 11)*
Session ..... 306 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3342
District ..... 306 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3342
Member
since 1995

♦ **Flanagan, Robert L.** *(Dist. 14B)*
Session ..... 226 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3200
District ..... 12400 Clarksville Pike
address ..... Clarksville 21029-1225
410-988-9818
Member
since 1987

♦ **Franchot, Peter** *(Dist. 20)*
Session ..... 424 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3460
District ..... 7111 Sycamore Ave.
address ..... Takoma Park 20912-4634
301-270-8417
Member
since 1987

♦ **Frank, Robert L.** *(Dist. 11)*
Session ..... 306 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3342
District ..... 306 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3342
Member
since 1995

♦ **Frush, Barbara** *(Dist. 21)*
Session ..... 210 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3114
District ..... 210 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3114
Member
since 1995

♦ **Fry, Donald C.** *(Dist. 35A)*
Session ..... 326 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3289
District ..... 1714 W. Jarrettsville Rd.
address ..... Jarrettsville 21084-1524
410-836-6747
Member
since 1991

Calling your representatives in Annapolis is a local call from the Baltimore and Washington areas. From the Baltimore area, dial the exchange 841; from the Washington area, dial the exchange 858; outside the Baltimore/Washington areas, dial 800-492-7122.

- **Fulton, Tony E.** *(Dist. 40)*
  Session ..... 317 House Office Bldg.
  address..... Annapolis 21401-1991
  ext. 3277
  District ..... 3501 Dennlyn Rd.
  address..... Baltimore 21215-7416
  410-578-1817
  Member
  since..... 1987

- **Genn, Gilbert J.** *(Dist. 16)*
  Session ..... 220 House Office Bldg.
  address..... Annapolis 21401-1991
  ext. 3045
  District ..... 1 Central Plaza
  address..... Suite 1008
  11300 Rockville Pike
  Rockville 20852-3035
  301-881-7700
  Member
  since..... 1987

- **Getty, Joseph M.** *(Dist. 5)*
  Session ..... 322 House Office Bldg.
  address..... Annapolis 21401-1991
  ext. 3371
  District ..... 322 House Office Bldg.
  address..... Annapolis 21401-1991
  ext. 3371
  Member
  since..... 1995

- **Goldwater, Marilyn** *(Dist. 16)*
  Session ..... 221 House Office Bldg.
  address..... Annapolis 21401-1991
  ext. 3019
  District ..... 221 House Office Bldg.
  address..... Annapolis 21401-1991
  ext. 3019
  Member
  since..... 1995

- **Gordon, Michael R.** *(Dist. 17)*
  Session ..... 151 House Office Bldg.
  address..... Annapolis 21401-1991
  ext. 3519
  District ..... 416 Hungerford Dr.
  address..... Suite 330
  Rockville 20850-4127
  301-294-2100
  Member
  since..... 1983

- **Greenip, Janet** *(Dist. 33)*
  Session ..... 214 House Office Bldg.
  address..... Annapolis 21401-1991
  ext. 3223
  District ..... 214 House Office Bldg.
  address..... Annapolis 21401-1991
  ext. 3223
  Member
  since..... 1995

- **Grosfeld, Sharon** *(Dist. 18)*
  Session ..... 223 House Office Bldg.
  address..... Annapolis 21401-1991
  ext. 3028
  District ..... 223 House Office Bldg.
  address..... Annapolis 21401-1991
  ext. 3028
  Member
  since..... 1995

- **Guns, Ronald A.** *(Dist. 36)*
  Session ..... 161 House Office Bldg.
  address..... Annapolis 21401-1991
  ext. 3534
  District ..... 107 Railroad Ave.
  address..... Elkton 21921-5535
  410-392-4422
  Member
  since..... 1983

- **Hammen, Peter** *(Dist. 46)*
  Session ..... 316 House Office Bldg.
  address..... Annapolis 21401-1991
  ext. 3303
  District ..... 316 House Office Bldg.
  address..... Annapolis 21401-1991
  ext. 3303
  Member
  since..... 1995

- **Harkins, James M.** *(Dist. 35A)*
  Session ..... 326 House Office Bldg.
  address..... Annapolis 21401-1991
  ext. 3289
  District ..... 4 East Jarrettsville Rd.
  address..... P.O. Box 149
  Forest Hill 21050-0149
  410-838-6636
  Member
  since..... 1991

- **Harrison, Hattie N.** *(Dist. 45)*
  Session ..... 427 House Office Bldg.
  address..... Annapolis 21401-1991
  ext. 3486
  District ..... 1054 N. Milton Ave.
  address..... Baltimore 21205-1319
  410-342-4414
  Member
  since..... 1973

- **Healey, Anne** *(Dist. 22A)*
  Session ..... 207 House Office Bldg.
  address..... Annapolis 21401-1991
  ext. 3058
  District ..... 3920 Madison St.
  address..... Hyattsville 20781-1749
  301-779-4515
  Member
  since..... 1991

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♦ **Hecht, Sue** *(Dist. 3)*
Session ..... 324 House Office Bldg.
address ..... Annapolis 21401-1991 ext. 3240
District ..... 324 House Office Bldg.
address ..... Annapolis 21401-1991 ext. 3240
Member since 1995

♦ **Heller, Henry B.** *(Dist. 19)*
Session ..... 429 House Office Bldg.
address ..... Annapolis 21401-1991 ext. 3528
District ..... 12706 Turkey Br. Pkwy.
address ..... Rockville 20853-3443 301-949-4265
Member since 1987

♦ **Hixson, Sheila Ellis** *(Dist. 20)*
Session ..... 100 House Office Bldg.
address ..... Annapolis 21401-1991 ext. 3469
District ..... 1008 Broadmore Circle
address ..... Silver Spring 20904-3108 301-384-4739
Member since 1976

♦ **Holt, Kenneth** *(Dist. 6)*
Session ..... 303 House Office Bldg.
address ..... Annapolis 21401-1991 ext. 3384
District ..... 303 House Office Bldg.
address ..... Annapolis 21401-1991 ext. 3384
Member since 1995

♦ **Howard, Carolyn J.B.** *(Dist. 24)*
Session ..... 204 House Office Bldg.
address ..... Annapolis 21401-1991 ext. 3065
District ..... 1891 Brightseat Rd.
address ..... Landover 20785-4256 301-772-2803
Member since ..... 1991 (also 1988-1990)

♦ **Hubbard, James W.** *(Dist. 23)*
Session ..... 208 House Office Bldg.
address ..... Annapolis 21401-1991 ext. 3103
District ..... 13305 Gallery Ct.
address ..... Bowie 20720-3866 301-464-6326
Member since 1992

♦ **Hughes, Brenda B.** *(Dist. 25)*
Session ..... 203 House Office Bldg.
address ..... Annapolis 21401-1991 ext. 3076
District ..... 706 Iona Terrace
address ..... Capital Heights 20743-3310 301-350-1532
Member since 1993

♦ **Hughes, Don B.** *(Dist. 37A)*
Session ..... 414 House Office Bldg.
address ..... Annapolis 21401-1991 ext. 3427
District ..... 414 House Office Bldg.
address ..... Annapolis 21401-1991 ext. 3427
Member since 1995

♦ **Hurson, John Adams** *(Dist. 18)*
Session ..... 313 House Office Bldg.
address ..... Annapolis 21401-1991 ext. 3464
District ..... 14 Kentbury Way
address ..... Bethesda 20814-4620 301-654-3513
Member since 1991

♦ **Hutchins, Thomas E.** *(Dist. 28)*
Session ..... 216 House Office Bldg.
address ..... Annapolis 21401-1991 ext. 3247
District ..... 216 House Office Bldg.
address ..... Annapolis 21401-1991 ext. 3247
Member since 1995

♦ **Jacobs, Nancy** *(Dist. 34)*
Session ..... 326 House Office Bldg.
address ..... Annapolis 21401-1991 ext. 3289
District ..... 326 House Office Bldg.
address ..... Annapolis 21401-1991 ext. 3289
Member since 1995

♦ **Kach, A. Wade** *(Dist. 9A)*
Session ..... 308 House Office Bldg.
address ..... Annapolis 21401-1991 ext. 3359
District ..... 214 Ashland Rd.
address ..... Cockeysville 21030-1902 410-527-1962
Member since 1975

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♦ **Kagan, Cheryl C.** *(Dist. 17)*
Session..... 224 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3046
District..... 224 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3046
Member
since..... 1995

♦ **Kelly, James M.** *(Dist. 9B)*
Session..... 308 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3359
District..... 201 Washington St.
address..... Cumberland 21502-2826
301-777-9000
Member
since..... 1987

♦ **Kirk, Ruth M.** *(Dist. 44)*
Session..... 315 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3263
District..... 501-C Pennsylvania Ave.
address..... Baltimore 21201-1949
410-383-2701
Member
since..... 1983

♦ **Kittleman, Robert H.** *(Dist. 14B)*
Session..... 411 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3401
District..... 12400 Clarksville Pike
address..... Clarksville 21029-1225
410-988-9818
Member
since..... 1983

♦ **Klausmeier, Katherine** *(Dist. 8)*
Session..... 307 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3365
District..... 307 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3365
Member
since..... 1995

♦ **Klima, Martha S.** *(Dist. 9A)*
Session..... 308 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3359
District..... 1403 Newport Place
address..... Lutherville 21093-5920
410-337-2799
Member
since..... 1983

♦ **Kopp, Nancy K.** *(Dist. 16)*
Session..... 221 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3019
District..... 6301 Dahlonega Rd.
address..... Bethesda 20816-2103
301-229-0385
Member
since..... 1975

♦ **Krysiak, Carolyn J.** *(Dist. 46)*
Session..... 316 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3303
District..... 364 Cornwall St.
address..... Baltimore 21224-2710
410-633-2927
Member
since..... 1991

♦ **La Vay, Richard** *(Dist. 15)*
Session..... 405 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3090
District..... 405 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3090
Member
since..... 1991

♦ **Leopold, John** *(Dist. 31)*
Session..... 213 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3217
District..... 213 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3217
Member
since..... 1995

♦ **Linton, Samuel C.** *(Dist. 28)*
Session..... 216 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3247
District..... 216 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3247
Member
since..... 1995

♦ **Love, Mary Ann** *(Dist. 32)*
Session..... 215 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3233
District..... Arundel Center North
address..... Suite 510
101 Crain Highway N.W.
Glen Burnie 21061-3060
410-761-9963
Member
since..... 1993

This information is accurate as of press time. Please contact the Department of Legislative Reference, ext. 3810, for current information.

♦ **Malone, James E.** *(Dist. 12A)*
Session ..... 304 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3378
District ..... 304 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3378
Member
since 1979

♦ **Mandel, Adrianne** *(Dist. 19)*
Session ..... 220 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3045
District ..... 220 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3045
Member
since 1995

♦ **Marriott, Salima Siler** *(Dist. 40)*
Session ..... 317 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3277
District ..... 4515 Homer Ave.
address ..... Baltimore 21215-6302
410-664-1228
Member
since 1991

♦ **McClenahan, Charles A.** *(Dist. 38)*
Session ..... 412 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3433
District ..... 4988 Annemessex Rd.
address ..... Crisfield 21817-0870
410-968-0870
Member
since 1992

♦ **McHale, Brian K.** *(Dist. 47A)*
Session ..... 310 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3319
District ..... 801 Light St.
address ..... 2nd Floor
Baltimore 21230-3912
410-244-8400
Member
since 1990

♦ **McIntosh, Maggie** (Dist. 42)
Session ..... 319 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3297
District ..... Northwood Shopping Ctr.
address ..... 1532 Havenwood Rd.
Baltimore 21218-1694
410-243-3904
Member
since 1992

♦ **McKee, Robert A.** *(Dist. 2A)*
Session ..... 321 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3447
District ..... 321 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3447
Member
since 1995

♦ **Menes, Pauline H.** *(Dist. 21)*
Session ..... 210 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3114
District ..... 3517 Marlbrough Way
address ..... College Park 20740-3925
301-935-6270
Member
since 1967

♦ **Minnick, Joseph J. "Sonny"** *(Dist. 7)*
Session ..... 305 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3332
District ..... 305 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3332
Member
since 1995

♦ **Mitchell, Clarence, IV** *(Dist. 44)*
Session ..... 315 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3263
District ..... 315 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3263
Member
since 1995

♦ **Mitchell, Van T.** *(Dist. 28)*
Session ..... 216 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3247
District ..... 216 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3247
Member
since 1995

♦ **Mohorovic, Jacob J., Jr.** *(Dist. 7)*
Session ..... 305 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3334
District ..... 305 House Office Bldg.
address ..... Annapolis 21401-1991
..... ext. 3334
Member
since 1995

Calling your representatives in Annapolis is a local call from the Baltimore and Washington areas. From the Baltimore area, dial the exchange 841; from the Washington area, dial the exchange 858; outside the Baltimore/Washington areas, dial 800-492-7122.

♦ **Montague, Kenneth C., Jr.** *(Dist. 43)*
Session ..... 310 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3259
District ..... Northwood Shopping Ctr.
address ..... 1532 Havenwood Rd.
Baltimore 21218-1694
410-243-3904
Member
since 1987

♦ **Morgan, John S.** *(Dist. 13B)*
Session ..... 226 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3200
District ..... 8610 Washington Blvd.
address ..... Suite 210B
Jessup 20794-9499
301-776-0806
Member
since 1991

♦ **Morhaim, Dan K.** *(Dist. 11)*
Session ..... 306 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3342
District ..... 306 House Office Bldg.
address ..... Annapolis 21401-199
ext. 3342
Member
since 1995

♦ **Mossburg, Mathew** *(Dist. 39)*
Session ..... 225 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3037
District ..... 225 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3037
Member
since 1995

♦ **Murphy, Donald E.** *(Dist. 12A)*
Session ..... 304 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3378
District ..... 304 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3378
Member
since 1995

♦ **Murphy, Margaret H.** *(Dist. 41)*
Session ..... 314 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3283
District ..... 4811 Liberty Hghts. Ave.
address ..... Baltimore 21207-7193
410-367-5811
Member
since 1978

♦ **Murphy, Timothy D.** *(Dist. 47A)*
Session ..... 310 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3319
District ..... 310 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3319
Member
since 1995

♦ **Muse, C. Anthony** *(Dist. 26)*
Session ..... 205 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3012
District ..... 205 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3012
Member
since 1995

♦ **Nathan-Pulliam, Shirley** *(Dist. 10)*
Session ..... 309 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3350
District ..... 309 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3350
Member
since 1995

♦ **Oaks, Nathaniel T.** *(Dist. 41)*
Session ..... 314 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3283
District ..... 314 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3283
Member
since 1995

♦ **O'Donnell, Anthony J.** *(Dist. 29C)*
Session ..... 217 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3314
District ..... 217 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3314
Member
since 1995

♦ **Owings, George W., III** *(Dist. 27B)*
Session ..... 217 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3231
District ..... P.O. Box 1177
address ..... 8217 Bayside Rd.
Chesapeake Bch 20732-1177
301-855-4100
Member
since 1988

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♦ **Palumbo, Richard A.** *(Dist. 22A)*
Session ..... 207 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3058
District ..... 4004 St. Barnabas Rd.
address ..... Suitland 20746-3202
301-423-8300
Member
since ..... 1990 (also 1979-1982,1986)
(Senate 1982-83)

♦ **Parker, Joan N.** *(Dist. 10)*
Session ..... 309 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3350
District ..... 309 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3350
Member
since 1995

♦ **Patterson, Obie** *(Dist. 26)*
Session ..... 205 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3012
District ..... 205 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3012
Member
since 1995

♦ **Pendergrass, Shane** *(Dist. 13A)*
Session ..... 209 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3205
District ..... 209 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3205
Member
since 1995

♦ **Perry, Marsha G.** *(Dist. 33)*
Session ..... 214 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3223
District ..... 1605 Edgerton Place
address ..... Crofton 21114-1504
410-721-7034
Member
since 1987

♦ **Petzold, Carol Stoker** *(Dist. 19)*
Session ..... 222 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3001
District ..... 14113 Chadwick Lane
address ..... Rockville 20853-2103
301-871-7413
Member
since 1987

♦ **Pitkin, Joan B.** *(Dist. 23)*
Session ..... 208 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3098
District ..... 12005 Long Ridge Lane
address ..... Bowie 20715-2353
301-262-0538
Member
since 1979

♦ **Poole, D. Bruce** *(Dist. 2B)*
Session ..... 321 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3451
District ..... 9743 Beaver Creek Church Rd.
address ..... Hagerstown 21740-1521
301-739-6409
Member
since 1987

♦ **Ports, James F., Jr.** *(Dist. 8)*
Session ..... 307 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3365
District ..... 4546 Fitch Ave.
address ..... Baltimore 21236-3912
410-529-8888
Member
since 1991

♦ **Preis, Mary Louise** *(Dist. 34)*
Session ..... 326 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3289
District ..... 9 West Courtland St.
address ..... Bel Air 21014-3701
410-838-5890
Member
since 1991

♦ **Proctor, James E., Jr.** *(Dist. 27A)*
Session ..... 206 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3083
District ..... 11204 Cedarville Rd.
address ..... Brandywine 20613-7690
301-888-9353
Member
since 1990

♦ **Rawlings, Howard P.** *(Dist. 40)*
Session ..... 131 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3407
District ..... 3502 Sequoia Ave.
address ..... Baltimore 21215-7211
410-466-4224
Member
since 1979

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♦ **Redmer, Alfred W., Jr.** *(Dist. 8)*
Session ..... 307 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3365
District ..... 4134 East Joppa Rd.
address..... Suite 106
Baltimore 21236
410-529-8888
Member
since..... 1991

♦ **Rosapepe, James C.** *(Dist. 21)*
Session ..... 100 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3521
District ..... 1331 H St., N.W.
address..... Suite 300
Washington, DC 20005-4706
202-628-6041
Member
since..... 1987

♦ **Rosenberg, Samuel I.** *(Dist. 42)*
Session ..... 319 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3297
District ..... 6615 Reisterstown Rd.
address..... Suite 301
Baltimore 21215-2603
410-358-2712
Member
since..... 1983

♦ **Rudolph, David D.** *(Dist. 35B)*
Session ..... 403 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3444
District ..... 403 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3444
Member
since..... 1995

♦ **Rzepkowski, James E.** *(Dist. 32)*
Session ..... 215 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3233
District ..... 215 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3233
Member
since..... 1995

♦ **Schade, Victoria L.** *(Dist. 31)*
Session ..... 213 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3217
District ..... 213 House Office Bldg.
address..... Annapolis 21401-199
ext. 3217
Member
since..... 1995

Schisler, Kenneth D. (*Dist. 37B*)
Session ..... 415 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3429
District ..... 5 Federal St.
address..... Suite 223
P.O. Box 1936
Easton 21601-1936
410-822-8682
Member
since..... 1991

♦ **Shriver, Mark K.** *(Dist. 15)*
Session ..... 224 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3046
District ..... 224 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3046
Member
since..... 1995

♦ **Slade, John Frank, III**
(Dist. 29B)
Session ..... 217 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3314
District ..... 24 Courthouse Dr.
address..... P.O. Box 288
Leonardtown 20650-0288
301-475-5151
301-994-2930
Member
since..... 1983

♦ **Snodgrass, Louise B.**
(Dist. 3)
Session ..... 324 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3240
District ..... 324 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3240
Member
since..... 1995

♦ **Stocksdale, Nance Reter** *(Dist. 5)*
Session ..... 322 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3371
District ..... 322 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3371
Member
since..... 1995

♦ **Stull, Paul S.** *(Dist. 4A)*
Session ..... 323 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3107
District ..... 323 House Office Bldg.
address..... Annapolis 21401-1991
ext. 3107
Member
since..... 1995

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♦ **Stup, J. Anita** *(Dist. 3)*
Session ..... 324 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3240
District ..... 153 West Patrick St.
address ..... Suite A
Frederick 21701-5513
301-695-0075
Member
since 1991

♦ **Taylor, Casper R., Jr.** *(Dist. 1C)*
Session ..... State House, Rm. 100
address ..... Annapolis 21401-1991
ext. 3800
District ..... 316 Prince George's St.
address ..... Cumberland 21502-3658
301-724-9234
Member
since 1975

♦ **Turner, Frank S.** *(Dist. 13A)*
Session ..... 209 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3205
District ..... 209 House Office Bldg.
address ..... Annapolis 21401-1991
..... ext. 3205
Member
since 1995

♦ **Valderrama, David M.** *(Dist. 26)*
Session ..... 205 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3012
District ..... 9708 Potomac Dr.
address ..... Fort Washington 20744-6935
301-839-7247
Member
since 1991

♦ **Vallario, Joseph F., Jr.** *(Dist. 27A)*
Session ..... 121 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3488
District ..... 5210 Auth Rd., 6th Fl.
address ..... Suitland 20746-4394
301-423-8100
Member
since 1975

♦ **Walkup, Mary Roe** *(Dist. 36)*
Session ..... 423 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3449
District ..... 423 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3449
Member
since 1995

♦ **Weir, Michael H.** *(Dist. 6)*
Session ..... 303 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3384
District ..... 611 Weir Lane
address ..... Essex 21221-1642
410-686-4947
Member
since 1975

♦ **Wood, John F., Jr.** *(Dist. 29A)*
Session ..... 141 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3502
District ..... 6230 Waldorf
address ..... Leonardtown Rd.
Mechanicsville 20659-3206
301-884-2345
Member
since 1987

♦ **Workman, Betty** *(Dist. 1B)*
Session ..... 320 House Office Bldg.
address ..... Annapolis 21401-1991
ext. 3462
District ..... 65 La Vale Ct.
address ..... Cumberland 21502-7420
301-729-2041
Member
since 1987

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Maryland congressional legislators

During 1995, legislation that affects health care will be considered at the federal level, as well as in the Maryland General Assembly. Below are the names, addresses, committee appointments, and phone and fax numbers of Maryland senators and representatives.

- **Senator Paul S. Sarbanes** (D)
  309 Hart Senate Office Building
  United States Senate
  Washington, DC 20510
  Phone: 202-224-4524
  Fax: 202-224-1651
  District: 410-962-4436
  Committees: Banking, Housing, and Urban Affairs; Budget; Foreign Relations; Joint Economic (vice chairperson)

- **Senator Barbara A. Mikulski** (D)
  709 Hart Senate Office Building
  United States Senate
  Washington, DC 20510
  Phone: 202-224-4654
  Fax: 202-224-8858
  District: 410-962-4510
  Committees: Appropriations; Labor and Human Resources; Select Ethics

- **Representative Wayne Gilchrest** (R-1st)
  332 Cannon House Office Building
  United States House of Representatives
  Washington, DC 20515
  Phone: 202-225-5311
  Fax: 202-225-0254
  District: 410-778-9407
  Committees: Resources; Transportation and Infrastructure

- **Representative Robert L. Ehrlich, Jr.** (R-2nd)
  315 Cannon House Office Building
  United States House of Representatives
  Washington, DC 20515
  Phone: 202-225-3061
  Fax: 202-225-3094
  District: 410-337-7222
  Committees: Banking; Government Reform and Oversight

- **Representative Benjamin L. Cardin** (D-3rd)
  104 Cannon House Office Building
  United States House of Representatives
  Washington, DC 20515
  Phone: 202-225-4016
  Fax: 202-225-9219
  District: 410-433-8886
  Committees: Standards of Official Conduct (Ethics); Ways and Means

- **Representative Albert Wynn** (D-4th)
  418 Cannon House Office Building
  United States House of Representatives
  Washington, DC 20515
  Phone: 202-225-8699
  Fax: 202-225-8714
  District: 301-773-4094
  Committees: International Relations; Banking and Financial Services

- **Representative Steny H. Hoyer** (D-5th)
  1705 Longworth House Office Building
  United States House of Representatives
  Washington, DC 20515
  Phone: 202-225-4131
  Fax: 202-225-4300
  District: 301-464-6440
  Committees: Appropriations; House Administration

- **Representative Roscoe Bartlett** (R-6th)
  322 Cannon House Office Building
  United States House of Representatives
  Washington, DC 20515
  Phone: 202-225-2721
  Fax: 202-225-2193
  District: 301-694-3030
  Committees: Armed Services; Science, Space, and Technology; Small Business

- **Representative Kweisi Mfume** (D-7th)
  2419 Rayburn House Office Building
  United States House of Representatives
  Washington, DC 20515
  Phone: 202-225-4741
  Fax: 202-225-3178
  District: 410-367-1900
  Committees: Banking, Finance, and Urban Affairs; Small Business; Standards of Official Conduct (Ethics)

- **Representative Constance A. Morella** (R-8th)
  106 Cannon House Office Building
  United States House of Representatives
  Washington, DC 20515
  Phone: 202-225-5341
  Fax: 202-225-1389
  District: 301-424-3501
  Committees: Science; Government Reform and Oversight

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In Memoriam

Edgar A. Bering Jr., M.D., a resident of Oxford, Maryland, and noted neurosurgeon and medical researcher, died August 11, 1994. Born in Salt Lake City, Dr. Bering graduated from Harvard Medical School in 1939 and achieved international recognition as an alpine skier on the U.S. team. While serving in the Navy during World War II, he invented the fibrin foam type of surgical sponge and contributed to the development of wound dressings that were pre-medicated with antibiotics. In addition to studying mathematics and statistics at Columbia University, Dr. Bering held the Harvard Travelling Fellowship, which he spent at Queen Square Hospital in London in 1948. Following a residency in neurosurgery, he joined the Harvard Medical School faculty, specializing in pediatric neurosurgery. He moved to Washington, DC, in 1963, where he worked at the National Center for Disease and Blindness. In 1972, he joined the staff of Memorial Hospital in Easton, Maryland, where he served as chief of staff until his retirement in 1987. A founding member of the Neurosurgical Society of America and a Fellow of the Harvey Cushing Society, Dr. Bering was an active member of several medical and civic societies. He was 77.

Morton D. Berkow, M.D., an anesthesiologist and former head of the lithotripsy unit at Sinai Hospital, died of cancer October 29, 1994. Born in Baltimore, Dr. Berkow was a graduate of Franklin and Marshall College in Lancaster, Pennsylvania, and the George Washington University School of Medicine in Washington, DC. In addition, he attended college in the Navy's V-12 program and served as a medical officer during the Korean War. Dr. Berkow served his internship and residency at St. Joseph Hospital in Lancaster. He returned to Maryland to join the staff at Sinai Hospital, where he worked for 34 years until his retirement in 1989. A former president of the local chapter of the Delta Epsilon medical fraternity, Dr. Berkow was a member of several societies. He was 68.

Andrew J. Brennan, M.D., a 30-year practitioner and Chevy Chase resident, died at Suburban Hospital November 26, 1994, of a heart attack. Dr. Brennan received his medical degree from Georgetown University School of Medicine in 1934, interned at Mercy Hospital in Wilkes Barre, Pennsylvania, and became a medical officer in the Civilian Conservation Corps. Dr. Brennan had a private practice in Birdboro, Pennsylvania, until 1941, when he was called to active duty for the Army Air Force. He attended the School of Aviation Medicine at Randolph Field in San Antonio, Texas, and served as a flight surgeon during World War II. After the war, Dr. Brennan continued his medical education at the University of Pennsylvania School of Medicine, George Washington University School of Medicine, New York Post Graduate School, and the Medical College of Virginia. He completed his residency in internal medicine at Mount Alto Veterans Hospital in Washington, DC, where he served as assistant chief of medicine. In addition, he was director of the Allergy Clinic at V.A. Hospital for 19 years. Dr. Brennan was a member of several medical societies, on the faculties of the medical schools at Georgetown and George Washington universities, and held staff appointments there as well as at Holy Cross and Suburban hospitals. Dr. Brennan was 86.

Ernest A. Dettbarn, M.D., a long-time resident of Frederick, Maryland, died at Memorial Hospital in Easton December 3, 1994. Born in Baltimore, Dr. Dettbarn received his medical degree from the University of Maryland School of Medicine in 1951. He served his internship at the Lutheran Hospital of Maryland in Baltimore, and from 1952 until 1955, practiced medicine in Frederick. After serving as a medical officer in the U.S. Navy, Dr. Dettbarn returned to private practice in 1957, and was also on the staff of Frederick Memorial Hospital. While at the hospital, he served as chief of the medical department and was instrumental in establishing a department of family practice. In 1979, he accepted the position of chief of the physical examination section at Fort Dix, New Jersey. At Fort Dix, Dr. Dettbarn was assistant chief of the outpatient clinic and chief of the acute infectious disease ward at Walson Army Hospital. He also served as the medical director for the deployment of troops to Desert Shield and Desert Storm. He retired to St. Michaels, Maryland, in 1991. Dr. Dettbarn was active in numerous professional and community activities; he was a charter member of the Frederick County Heart Association and a former president of the Frederick County Medical Society. He was 70.

John H. Hirschfeld, M.D., a Pikesville resident and lung specialist, died December 6, 1994, of cancer. Born in Vienna, Austria, he earned his medical degree at the University of Vienna and came to the United States in 1938. Before opening a private practice in 1945 in Northeast Baltimore, he served on the staff of the Victor Cullen State Hospital in Sabillasville. In addition to his practice, Dr. Hirschfeld was an instructor in laryngology

at the University of Maryland School of Medicine. While there, he researched tuberculosis and other lung diseases and found they were often related to alcoholism. In 1960, Dr. Hirschfeld became a member of the Public Health and Preventive Medicine Committee of Med Chi and later became chairperson of its Subcommittee on Alcoholism. In addition, he served on the executive committee of the Baltimore Area Council on Alcoholism and was president from 1966 until 1969. He was awarded the Bronze Key award of the American Council on Alcoholism for his advocacy of detoxification and treatment of alcoholics. A fellow of the American College of Chest Physicians, Dr. Hirschfeld had been a staff member at Greater Baltimore Medical Center and Church, Maryland General, Good Samaritan, and Sinai hospitals. He was 81.

John Matthai Scott, M.D., a Baltimore internist, died December 26, 1994, of respiratory failure in his Roland Park home. Born in Roland Park, Dr. Scott earned his undergraduate degree at The Johns Hopkins University and in 1938, his medical degree from the University of Maryland School of Medicine. He served his internship at Maryland General Hospital and his residency at New York Hospital at Cornell University. While at New York Hospital, Dr. Scott joined the U.S. Army and served as a physician in the South Pacific during World War II. Returning to Baltimore in 1946, he opened a private practice in Roland Park and practiced internal medicine for 44 years until his retirement in 1990. He served on the staffs of Johns Hopkins and Union Memorial hospitals and the Greater Baltimore Medical Center. In addition, he was on the faculty of The Johns Hopkins School of Medicine until his retirement. Serving on the board of directors for the Episcopal Ministries to the Aging, Dr. Scott was known for his community and church service. He was 83.

James E. Toher, M.D., former chairperson of the department of obstetrics and gynecology at St. Agnes Hospital, died December 20, 1994, of heart failure at his home in Catonsville. Originally from Rhode Island, Dr. Toher earned his bachelor's degree from Providence College in 1950, and his medical degree from Georgetown University School of Medicine in 1954. He completed his internship and residency in ob/gyn at St. Agnes Hospital and postgraduate training at Cook County Hospital in Chicago. In 1942, Dr. Toher enlisted in the U.S. Army Air Force and served as a navigator aboard B-17s. He returned to St. Agnes Hospital in Baltimore, where he spent his entire career until his retirement in 1986. In 1973, he was appointed ob/gyn head and in 1980, he organized the obstetrical group at the hospital and introduced microsurgery to the hospital. Dr. Toher was active in the Brazilian mission of the Pallottine Fathers of Baltimore, and in the early 1970s, traveled to Brazil to evaluate hospitals and medical clinics there. A fellow of the American College of Obstetricians and Gynecologists and a diplomate of the National Board of Medical Examiners, Dr. Toher was very active in professional and community organizations. He was 70.

No additional information was available at press time for the following members:

John B. Brady, M.D.
Montgomery County ..... February 10, 1994

Naci Buyukunsal, M.D.
Carroll County ..... October 1, 1994

Malcolm Freed, M.D.
Baltimore County ..... November 19, 1994

Maurice F. Klawans, M.D.
Anne Arundel County

Robert C. Macon, M.D.
Montgomery County ..... November 24, 1994

Erwin Witkin, M.D.
Baltimore County ..... November 23, 1994

STATUE OF DR. ARIS T. ALLEN ERECTED IN ANNAPOLIS

In October 1994, Faye W. Allen, M.D., unveiled a monument dedicated to her late husband, Dr. Aris T. Allen, M.D. Located at the intersection of Forest Drive and Aris T. Allen Boulevard in Annapolis, the statue honors Dr. Allen's achievements as a physician, community leader, legislator, and role model. Dr. Allen, a 1944 graduate of Howard University Medical School, was elected chief of staff at Anne Arundel General Hospital in 1977. He served in the Maryland House of Delegates from 1967 through 1974 and was re-elected in 1990 at the age of 80. In 1970, then-Med Chi President Russell S. Fisher, M.D., presented Dr. Allen with the Robins Award for outstanding community service by a physician. Dr. Allen died in February 1991.

Alliance

Legislative Activities of the Alliance

In 1994, the annual "Day in Annapolis" was held January 24 in the stately Joint Hearing Room. The morning began with informative talks by Med Chi Chief Executive Officer Angelo Troisi; then Med Chi President Joseph Snyder, M.D.; Med Chi general counsel Angus Everton; and Med Chi lobbyist Joseph Schwartz, III. Most of the talks centered around the Clinton health plan and the various bills to reinstate a cap on non-economic damages in malpractice suits. An informative and lengthy question-and-answer session followed.

We were also very fortunate to hear Dr. Mary Mussman, the deputy secretary of public health services from the Department of Health and Mental Hygiene, speak about the serious public health problem of smoking. She asked Alliance members to support the passage and enforcement of bills that would restrict minors' access to tobacco products by limiting the placement of tobacco vending machines to areas that are frequented only by adults or inaccessible to minors. (The Alliance followed up on the issue by participating in an anti-smoking rally at St. John's College later in the year. The rally was attended by middle school children from all over the state who put on skits and brought cigarettes they had purchased to show the easy accessibility of cigarettes to minors. The rally was covered by the media and attended by the governor and a number of legislators.)

Our final speaker was Senator Mary Boergers from Montgomery County, who introduced a bill in the 1994 session that dealt with domestic violence. Her bill provided guidelines for police officers and physicians when they are confronted with domestic violence cases.

Lunch was held at the charming restaurant *La Piccola Roma* on Main Street. Several legislators attended and ate with their respective constituents. Alliance members presented achievement awards to Senator Patty Sher and Delegate Mike Busch. After lunch, several members met with their legislators while other members investigated the Annapolis dock area.

Our telephone call, letter writing, and personal visitation campaign was very successful last session; according to the *Washington Post*, legislators were so inundated with calls and faxes that they had to leave their telephones off the hook and unplug their fax machines.

The 1995 session of the Maryland General Assembly, which started January 11, will run through April. The Montgomery and Anne Arundel County Alliances have held receptions congratulating the new representatives and welcoming back those who were re-elected.

This year, both the "Day in Annapolis" and Doctor's Day will be held February 9. The "Day in Annapolis" is a great opportunity for Alliance members to meet with legislators and voice the concerns of the medical community regarding health issues and pending legislation. Some of the bills that Med Chi will be working on during the 1995 session include the patient protection bill and the ambulatory facility bill. Although we may not succeed in getting all the bills passed that are of concern to us, it is important to let our legislators know the view of the medical community.

We hope you will attend and have a productive and enjoyable day. (Come a day early and stay in one of the quaint historical inns in Annapolis).

LEAH PRICHEP
Mrs. Prichep is the state legislative chairperson. ■

MARYLAND

The Alliance always welcomes new members.

Alliance members support the physicians and are recognized for their contributions to health, education, and the promotion of quality health care in Maryland.

For information on becoming a member, call JoAnn Troisi at Med Chi's Alliance office.
539-0872 (Baltimore area)
1-800-492-1056 (toll free in MD)



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12th Annual Houston Evertt memorial course in urogynecology, 17 Cat 1 AMA credits.	**Feb. 24–25**
Pain treatment centers at a crossroads: a practical and conceptual reappraisal, 20 Cat 1 AMA credits. $350/physicians; $250/allied health professionals, residents, fellows.	**March 3–4**
Nuclear oncology, 16 Cat 1 AMA credits. $495/physicians; $395/residents, fellows, and allied health professionals.	**March 8–10**
Principles and practice of clinical MRI, at the Renaissance Hotel, Washington, DC. 21.5 Cat 1 AMA credits.	**March 23–26**
Fifth annual perspectives on clinical nutrition, 11 Cat 1 AMA credits.	**March 24–25**
Spectrum of developmental disabilities XVII, 20 Cat 1 AMA credits.	**March 27–29**
Diagnosis and treatment of neoplastic disorders, 13.5 Cat 1 AMA credits. $325/physicians; $150/residents, fellows, and allied health professionals.	**March 30–31**
36th Annual postgraduate institute for pathologists in clinical cytopathology, 136 Cat 1 AMA credits.	
Course A (Home Study)	**Feb–March**
Course B (Johns Hopkins Medical Institutions)	**April 3–14**
The care of patients with Alzheimer's and other dementias, at the Stouffer Harborplace Hotel, Baltimore, MD. 5.5 Cat 1 AMA credits available. $120/physicians; $75/residents, fellows, and allied health professionals.	**April 1**
23rd Annual pediatric trends, 42 Cat 1 AMA/AAP credits. $650/physicians; $450/residents and fellows.	**April 3–8**
Clinical care of the patient with HIV infection, at the Stouffer Harborplace Hotel, Baltimore, MD. 12.5 Cat 1 AMA credits. $325/physicians, $175/residents, fellows, and allied health professionals;	**April 6–7**
Current concepts in thyroid disease: update 1995, 8.5 Cat 1 AMA credits. $160/physicians; $30/residents and fellows.	**April 21**
Ninth annual mood disorders symposium, Cat 1 AMA credits pending. $50/DRADA members; $60/other.	**April 25**
Wilmer nursing conference	**April 28**
Pediatric allergy and immunology for the practitioner, 14 cat 1 AMA credits. $255/physicians; $175/residents and allied health professionals.	**May 4–5**
Contemporary issues in the diagnosis and treatment of low back pain	**May 4–6**
In vitro toxicology	**May 8–10**
Rheumatology nursing	**May 12–13**
40th Annual topics in clinical medicine, 40 cat 1 AMA credits.	**May 15–19**
Advanced pediatric life support, 20 cat 1 AMA credits.	**June 12–14**
Design and analysis in clinical trials, 15 cat 1 AMA credits.	**June 15–16**

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The department of radiology and radiological sciences offers several courses in abdominal and obstetrical ultrasound. Info: P. Williams, 410-955-3169.

Visiting physicians. Offered throughout the year for experience in the lab and participation in read-in sessions; by appointment only. 40 Cat 1 AMA/PRA credits. $500.

Johns Hopkins medical grand rounds. Accredited audiovisual continuing education series of case discussions for clinicians; 30 topics per year in five bimonthly programs. Individual and group subscriptions. 40 Cat 1 AMA/PRA credits. Info: 410-955-3988.

Johns Hopkins sports medicine grand rounds. Accredited continuing education series of case discussions by a different presenter on the first Thursday of each month. Info: Carol Kelly, 410-383-0600.

University of Maryland

For each course, additional information may be obtained by contacting the Program of Continuing Education, University of Maryland School of Medicine, Room 14-011, BRB, 655 W. Baltimore St., Baltimore, MD 21201 (410-706-3956) or by calling the phone number listed after a specific program. FAX 410-328-3103.

Maryland Otolaryngology, Head & Neck Surgical Society: evaluation & treatment of patients with chronic sinusitis, Baltimore, MD. 3 Cat 1 AMA credits. $165. Info: J.F. Biedlingmaier, M.D., 410-225-8072. — **Feb. 21**

Physician forum HIV: HIV care provision—medical, legal, and ethical dilemmas, at the Brass Elephant Restaurant in Baltimore, MD. 1 Cat 1 AMA credit. Info: Sylvia Scherr, 410-328-8639. — **March 16**

Maryland Otolaryngology, Head & Neck Surgical Society: resident research presentations, at the Greater Baltimore Medical Center, Towson, MD. 3 Cat 1 AMA credits. $165. Info: J.F. Biedlingmaier, M.D., 410-225-8072. — **April 25**

8th Annual trauma anesthesia & critical care symposium, at the Hyatt Regency Hotel in Baltimore, MD. Cat 1 AMA credits. Info: Kimberly Unitas, 410-328-2399. — **May 11–13**

Physician forum HIV: beyond the recommendations—how we really care for AIDS patients, at the Brass Elephant Restaurant in Baltimore, MD. 1 Cat 1 AMA credit. Info: Sylvia Scherr, 410-328-8639. — **May 18**

21st Annual family medicine review course, at the Princess Royale Ocean Suite Hotel in Ocean City, MD. Cat 1 AMA/AAFP credits. Info: Althea Pusateri, 410-706-3956. — **June 25–30**

Managing emergency medical services, at the University of Maryland Baltimore County (UMBC). Sponsored by the UMBC Department of Emergency Health Services and the Maryland Institute for Emergency Medical Services Systems. Info: Dr. Richard Bissell, 410-455-3776. — **July 2–28**

Miscellaneous meetings

Fifth annual dance medicine symposium, sponsored by Union Memorial Hospital, HealthSouth Spine and Physical Therapy Center and Goucher College, at the Todd Dance Studio of Goucher College. Info: Andrea DiStefano, P.T., 410-296-0511. — **March 11**

Fifth annual AAMI/FDA international standards conference on medical devices, "International standards and regulatory harmonization," at the Crystal Gateway Marriott Hotel in Washington, DC. Info: 800-332-2264, or 703-525-4890, ext. 260. — **March 16–17**

Fourth annual spring clinical nephrology meetings primary care nephrology program, sponsored by the National Kidney Foundation at the Sheraton Washington Hotel in Washington, DC. Info: 1-800-622-9010. — **March 24–25**

Clinical perspectives on violence conference, at Sheppard Pratt Conference Center, Baltimore, MD. 6 Cat 1 AMA/PRA credits. Fee: TBA. Info: Professional Education Programs, 410-938-4598. — **March 25**

Substance abuse '95: programs in policy and practice, at the George Washington University Medical Center. 5.5 Cat 1 AMA credits. Info: Martha Cosgrove, 202-994-4536. — **March 25**

Reflux and ulcer disease advanced laparoscopy course, at the George Washington University Medical Center. Info: Maria Gorrick, 202-994-4285. — **March 31**

Comprehensive HIV management update for the primary care physician, at the Palace Hotel in New York City. 21 Cat 1 AMA/AAFP/AAPA credits. Info: Svetlana Lisanti, 201-385-8080. — **March 31–April 2**

Third world congress on stress, trauma and coping in the emergency services professions, at the Sheraton Inner Harbor Hotel, Baltimore, MD. Info: 410-730-4311. — **April 19–23**

Clinical innovations in OB/GYN ultrasound, sponsored by Meetings & Management Techniques Plus and The American Institute of Ultrasound in Medicine, at the Lowes L'Enfant Plaza in Washington, DC. 14.5 Cat 1 AMA/PRA credits and 15 Formal Learning Cognates by ACOB/GYN. Info: Ann Boehme 516-561-4223. — **April 22–23**

Caring for the diabetic lower extremity: a practical approach for primary health care providers, sponsored by the American Diabetes Association, MD Affiliate, and the MD Podiatric Medical Association, at the Sheraton International Hotel, BWI Airport. 7 Cat 1 AMA credits. $125/physicians; $100/ACP members;$75/other health professionals. Info: 410-526-2900. — **April 28**

Third international symposium on maritime health, sponsored by the George Washington University Medical Center, at the Maritime Institute of Technology and Graduate Studies in Baltimore, MD. 14 Cat 1 AMA credits. $1200 before Feb. 28; $1350 after (includes lodging and some meals). Info: Karen Mayer, 202-994-3921. — **June 7–9**

2nd Annual intensive review of internal medicine, sponsored by the George Washington University Medical Center, at the Washington Marriott Hotel, Washington, DC. Info: Deborah Grant 202-994-4285. — **June 7–10**

3rd Annual board review in family medicine, sponsored by the George Washington University Medical Center, at the Marriott Crystal Gateway Hotel, Arlington, VA. 39 cat 1 AMA/AAFP credits. Info: Maria Gorrick, 202-994-4285. — **June 24–28**

6th Biannual gastroenterology board review course, sponsored by the George Washington University Medical Center, at the Grand Hyatt in Washington, DC. Fee and credits TBA. — **Oct. 7–11**

Miscellaneous meetings (continued)

Medical oncology board review course, sponsored by the George Washington University Medical Center, at the Ritz-Carlton Pentagon City in Arlington, VA. Fee and Credits TBA. **Oct. 8–12**

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Fluorescein angiography conference, sponsored by the Retina Center, Saint Joseph Hospital, Baltimore, MD, first and third Mondays of each month; 8:00–9:00 am. Fee: none. Info: R. Classon, 410-337-4500.

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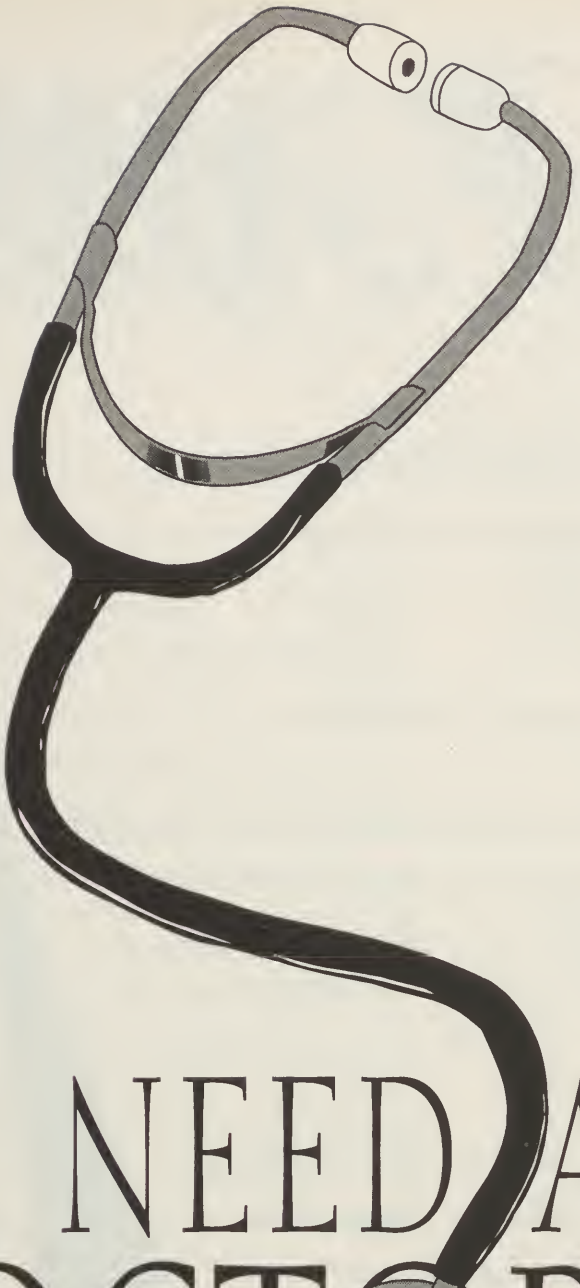
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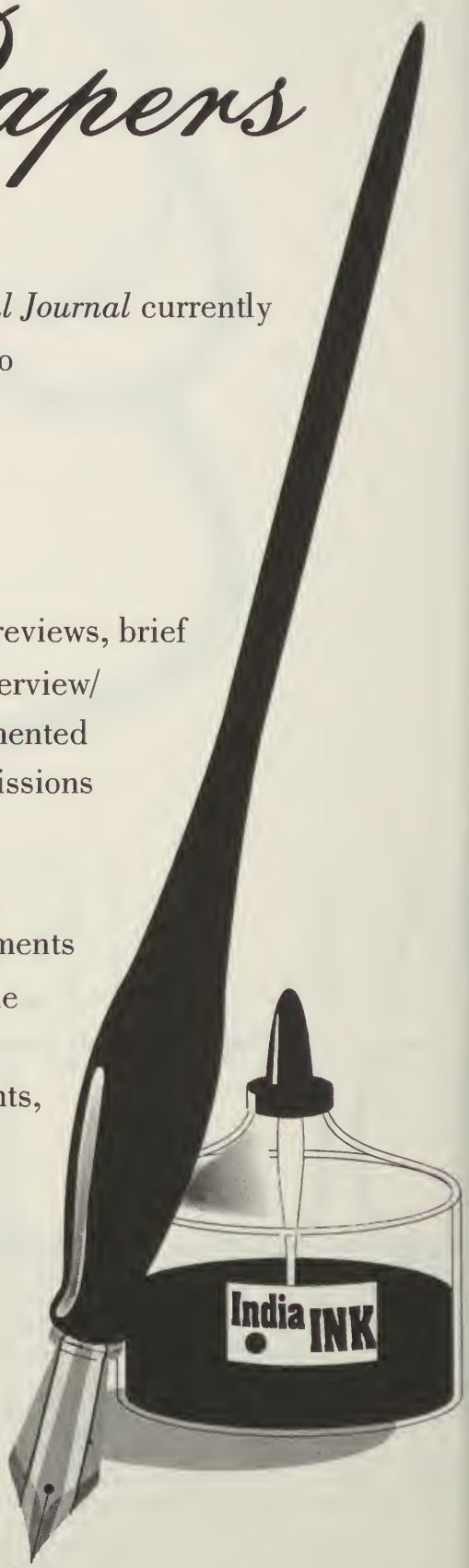
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All submissions should conform to requirements listed on the "Information for Authors" page of the *Maryland Medical Journal.* For further information or to obtain a copy of submission requirements, contact Mary Ann Ayd, Managing Editor, 1211 Cathedral Street, Baltimore, MD 21201; 410-539-0872 or 1-800-492-1056; FAX 410-547-0915.



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February, 1995

Cancer Incidence in Maryland - 1992

The Maryland Cancer Registry (MCR) has produced the first statewide report of cancer incidence in Maryland. The Maryland Cancer Registry Final Registry Data Report - 1992 includes full reporting by Maryland hospitals, freestanding laboratories and radiation treatment centers, data exchange with adjacent states, case finding from Maryland death records, quality control studies of case finding and validation of case information. All providers of case information submit reports in an electronic format and in accordance with the 1992 reporting law.[1] In addition to the statewide data, 1992 statistics are compiled for the five regions of Maryland and each of the 24 local jurisdictions. Preliminary reports for the periods 1983-88 and 1989-91 have been released previously for the Eastern Shore, Western Maryland, and the Baltimore Metropolitan area.[2]

Case finding is still short of the numbers expected. Annually the American Cancer Society, in cooperation with the National Cancer Institute, calculates and publishes an estimated number of cancer cases for the country, every state, the District of Columbia and the territories.[3] Using these estimates, 92% of the cases expected has been accessioned at the time of this report. Cases diagnosed or treated in Maryland are by law reported within six months of diagnosis or the initiation of medical care, whichever applies. Case accrual is not only a timely process, it is a continuous process. This report includes cases added through November 30, 1994. Table 1 shows the percentage of the cases expected which have been reported.

Table 1
Number of Actual & Expected Cases, and Percentage of Expected 1992 Maryland Cases Reported, by Region
Maryland Cancer Registry

Region Complete	# in MCR	# Expected	%
Baltimore Metro	10819	10536	102.7
Eastern Shore	1793	1561	114.9
National Capital	4455	6728	66.2
Southern Maryland	872	1067	81.7
Western Maryland	1743	1708	102

*Source: The MCR Final Data Report-1992, ACS defined cases.

Reporting at levels less than predicted is occurring in the National Capital area and Southern Maryland. The percentage complete is 55.8% for Prince George's County and 76.2% in Montgomery County. 14.3% and 24.6% of the cancer deaths in each county, respectively, occur outside the State.[4]

Southern Maryland has 81.7% of its estimated cases reported. The remainder of the State reaches 100% of expected, indicating good case ascertainment, when the expected are a true measure of the cases to be registered. Table 2 exhibits the number of cases diagnosed and expected by the four major cancer sites. With the exception of prostate, cases reported were 10-16% fewer than expected. Prostate cancers reported exceed the expected by nearly two-thirds.

Table 2
Number of 1992 Maryland Cases Diagnosed and Expected, by Site, Maryland Cancer Registry

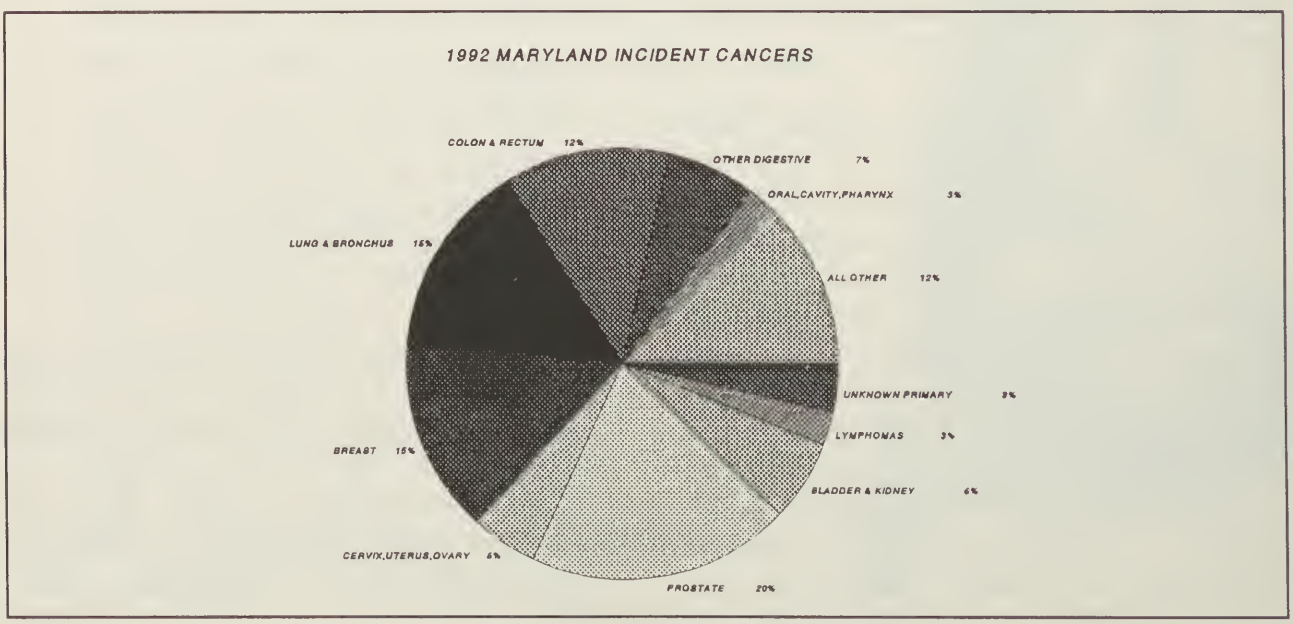
Cancer Site	# in MCR	# Expected
All sites	20047	21600
Breast (females)	2936	3500
Lung and bronchus	2972	3300
Colon and rectum	2433	2900
Prostate (males)	3947	2400
All other sites	7759	9500

* Source: The MCR Final Data Report-1992

The most frequently diagnosed cancer sites are similar to but not in the same rank order as sites having the highest mortality. This is due to differences in survival for each site and an abundance of case finding. Prostate cancer was the most frequently reported cancer site. Lung and bronchus in the whole population and breast among women are the next most frequently reported sites. Due to lung and bronchus having poor survivability, these sites are first in mortality. Breast, which has good treatment outcomes when detected and treated early, is second in mortality among women. Cancers of the colon and rectum amounted to 12% of all cases. The figure below shows the distribution of cases.

Incidence Rates - Maryland 1992

The 1992 age-adjusted (U.S. 1970 standard) cancer incidence rate in Maryland is 385 per 100,000 population. This rate is similar to the 1990 incidence rate obtained by the National Cancer Institute's Surveillance and Epidemiology and End Results Program (SEER), ten U.S. sites having active surveillance and follow-up of cancer cases.[5]



This is true also with colon and rectum and female breast cancer when one compares the 1992 Maryland rate to 1990 SEER.[5] Table 3 displays the rates for the four major cancers.

Table 3
Cancer Incidence*, Total and Selected Sites, Maryland - 1992 and U.S. - 1990*****

Cancer Site	1992 Maryland	1990 SEER
All Sites	385.8	389.2
Lung and bronchus	58.9	57.3
Colon and rectum	46	47.6
Breast (females)	99.1	108.8
Prostate (males)	183.3	128.9

*Incidence rate is cases per 100,000 population, age-adjusted to U.S. 1970 standard.
**Source: The MCR Final Data Report - 1992, 1994.
***Source: Cancer Statistics Review 1973-1990, 1993.

The highest overall rates, were found to be in the Southern Maryland, despite low ascertainment. The lowest rates, however, were found in the National Capital area where underreporting has occurred.

Table 4
Ranks among Maryland Regions for All Cancers, Lung & Bronchus (L&B), Prostate (Pros), Breast (Br), and Colon & Rectum (C&R)

	Total	L&B	Pros	Br	C&R
SMD	1	1	1	5	1
BMetro	2	3	2	1	4
EShore	3	2	3	3	3
NW	4	4	5	2	2
NCap.	5	5	4	4	5

Southern Maryland had the highest rates of cancer for, lung and bronchus, prostate and colon and rectum and the lowest for breast cancer. After the National Capital Area, Northwest Maryland was the lowest for lung and bronchus and Baltimore Metro was the lowest for colon and rectum. Northwest Maryland was lowest in prostate.

Cancer rates among men for lung and bronchus and prostate cancer are statistically higher than the 1990 SEER rate.

Cancer rates for men and women in Maryland differ as they do in the U.S.; men are diagnosed with cancer (all sites) 1.6 times as often as women and more often than SEER.[2] Men in Maryland were more likely to have been diagnosed with larynx or esophagus cancer when compared to women and least likely to be diagnosed with endocrine gland cancer.*

Nonwhites in Maryland are diagnosed as often as whites with cancer. Nonwhites compared to whites more often have myelomas and cervix, esophagus, and liver cancers. The largest ratio of whites to nonwhites is observed in melanomas and the sites of the lips and eyes. Rates for each race group are lower in Maryland than are those reported by SEER. Table 5 displays a few of these rate ratios.

Table 5
Rate Ratios Comparing Whites and Females in Maryland, 1992*

Cancer Site	Nonwhite/White	Males/Females
All sites	1.0	1.6
Lung and bronchus	1.1	2.1
Colon and rectum	1.1	1.4
Breast (females)	0.9	---
Prostate (males	1.2	---

*Source: The MCR Final Data Report - 1992.

FINDINGS - 1992

Maryland lung and bronchus age-specific rates are higher than those reported by SEER for ages 60-79 while rates for age 35-59 are low. This cohort effect may reflect specific occupational and tobacco exposures occurring between 1935 & 1974. The cohort effect is apparent among whites in the rural areas of Maryland.

Maryland breast cancer incidence is lower than seen by SEER - 1990, for screening aged women (50-74). Maryland women have more local stage cancer diagnosed than reported by SEER - 1990. Low breast cancer incidence in Maryland may reflect active screening and more truly incident cases. Declines in mortality among screening aged women have occurred in parts of Maryland already.

Maryland colon and rectum cancer rates are lower for every sex, race, and race-sex group. Fewer Marylanders are diagnosed with local disease. Early diagnosis is warranted.

Maryland prostate cancer rate is 60% higher than seen by SEER - 1990. Case finding exceeded expectations in all regions, in both racial groups, and proportionately more often among men 40-59 compared to men 60 and older. These findings are probably due to active PSA testing and subsequent case finding; national trend data suggest this.

Cancers which have unknown stage are reported more often in Maryland. As the quality of reporting improves, it is expected that this difference will dissipate. Under reporting occurs in the Washington, D.C. area despite complete reporting from facilities and adjacent jurisdictions registries.

SUMMARY

Special studies of Maryland incidence data have been initiated.

Maryland Cancer Control Plan priorities as follows have not changed in light of these data:**

- ☞ curb exposure to tobacco products;
- ☞ promote regular use of mammography and Pap smears;
- ☞ promote changes in diet - low fat, high fiber, more fruits and vegetables;
- ☞ study environmental exposures;
- ☞ review use of state of the art treatment; and,
- ☞ continue collection of useful data for program planning, policy making and research.

REFERENCES

1. Code of Maryland Regulations 10.14.01.

2. Preliminary MCR Regional Data Reports Eastern Shore, Baltimore Metropolitan Areas, and Northwestern Maryland, 1989-91.

3. American Cancer Society, Cancer Facts and Figures, 1992.

4. Source: Maryland Division of Vital Statistics, 1992 death file.

5. National Cancer Institute, Cancer Statistics Review, 1973-1990, 1993.

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*Endocrine gland cancers are ICD-9 codes of 193.0, 164.0, 194.0 - 194.9 which include thyroid and thymus.

**The addition possible to the plan being the examination of the possibility of the feasibility and efficaciousness of early detection of colon cancer.

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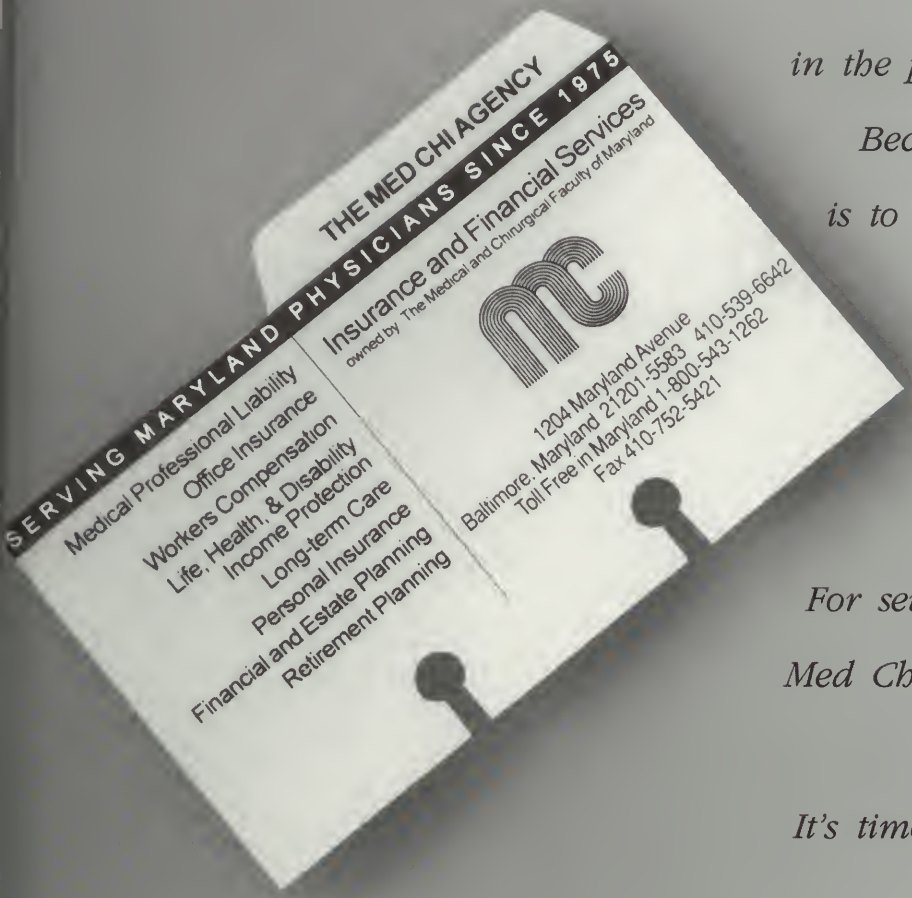
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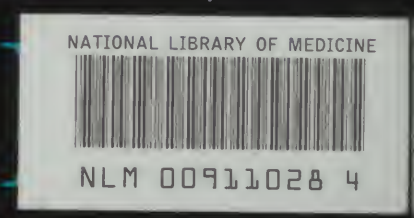
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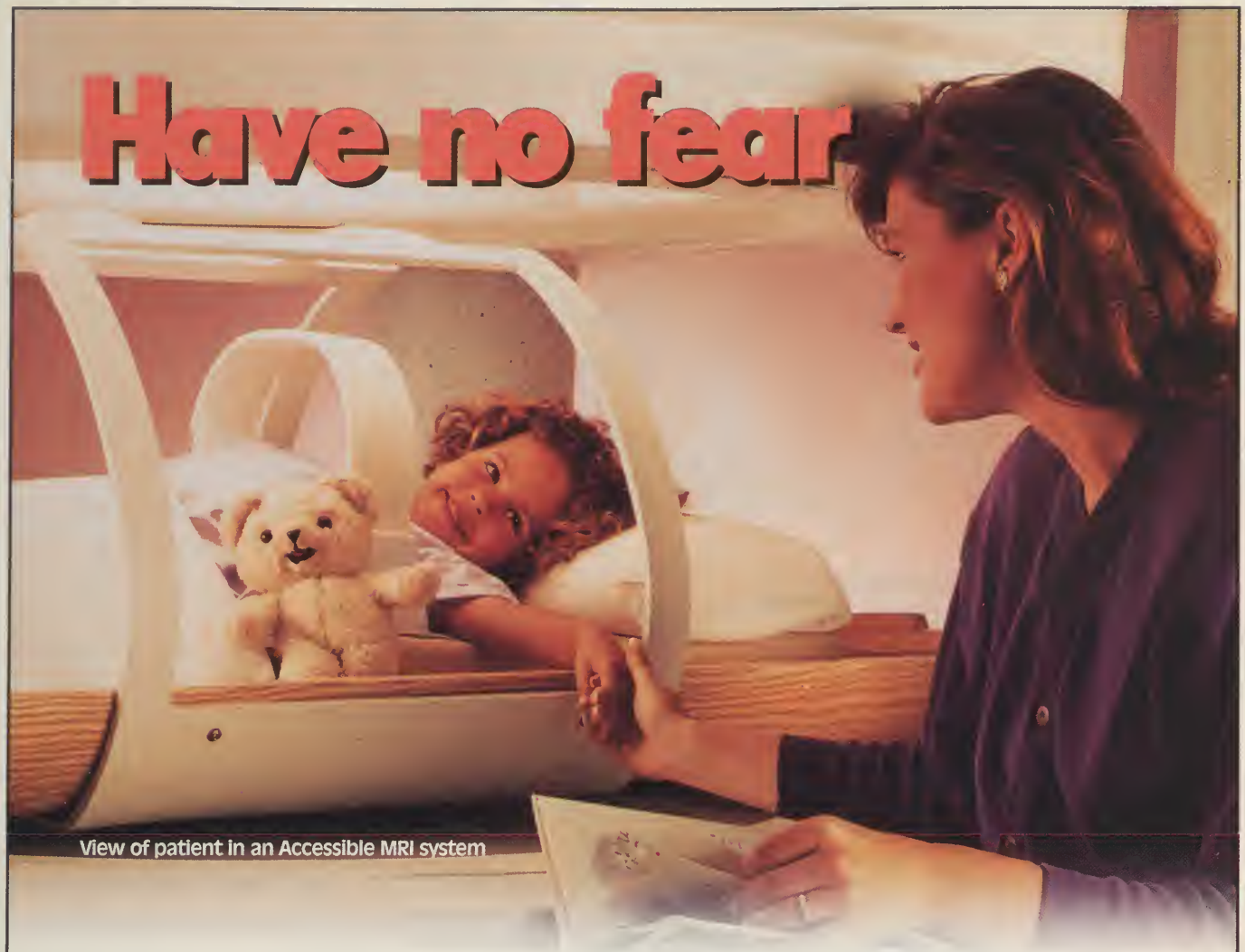
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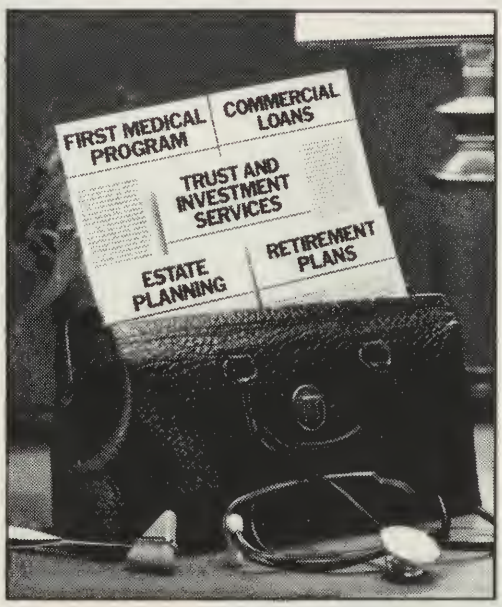
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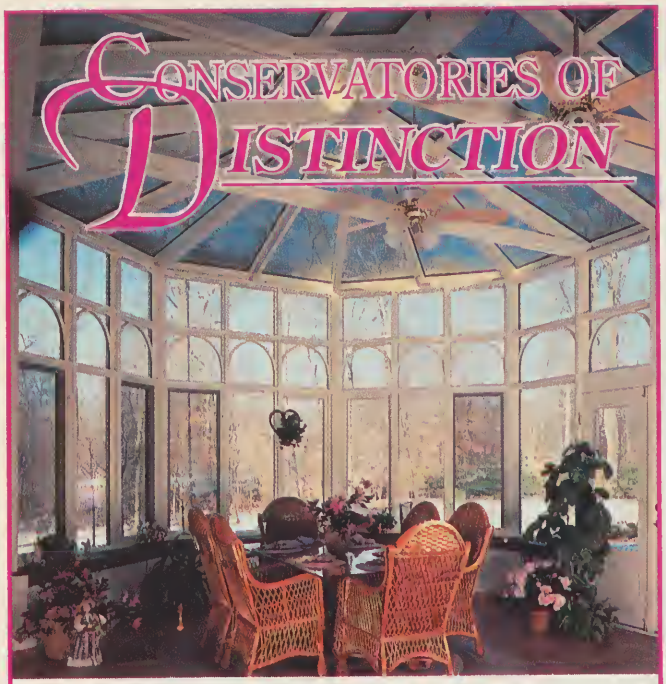
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Chief Executive Officer's Newsletter

March 1995

Annual Meeting Preliminary Program

The preliminary program for the 197th Annual Meeting of the Medical and Chirurgical Faculty of Maryland, "Outcome Studies— Impact on Medical Practice," immediately follows this issue of the *Chief Executive Officer's Newsletter.* The meeting will be held Thursday, May 4 through Saturday, May 6, 1995, at the Inn and Conference Center (formerly Adult Education Center), College Park, MD.

John R. Smith, M.D., President of Queen Anne's County Medical Society, dies

On February 2, 1995, Dr. John R. Smith, who since 1960 practiced internal medicine in Centreville, Maryland, died at age 71. In January of this year, Dr. Smith began serving his eighth term as president of the Queen Anne's County Medical Society.

Patient Access Brochures Available

Brochures entitled "For the Basic Right to Choose Your Doctor" are available to all Med Chi members. These brochures explain the Patient Access bills currently before the Maryland General Assembly and are designed to increase patient support for this legislation. Requests for the brochure can be made by calling Heather Johnson in the communications department at 410-539-0872 or 1-800-492-1056.

Address Correction

The address listed for Washington County Medical Society on page 195 of the recently published *Med Chi 1995 Membership Directory* was incorrect. The correct address is: Diane Richards, Executive Secretary, Washington County Medical Society, P.O. Box 172, Williamsport, MD 21795-0172. Please make this correction in your directory.

Directory Changes

Changes to the *Med Chi 1995 Membership Directory* will be published in the April 1995 issue of the *Maryland Medical Journal.* If you would like to include a change to your listing, please call Wanda Griebel in the membership department at 410-539-0872 or 1-800-492-1056, ext. 330.

Have a Health Tip?

The Public Relations Committee is preparing a series of consumer-oriented, health-related public service announcements that will be used during the *Sunday Rounds* program on WBJC. Announcements should focus on educating consumers about how to take better care of their health or how to handle minor medical problems (i.e. sprains, sunburn, etc.). The length of each announcement is limited to 20 seconds. If you have a health tip, or would like additional information, please call Ruth Seaby in the communications department at 410-539-0872 or 1-800-492-1056.

1995 AMA National Leadership Conference

The 1995 American Medical Association National Leadership Conference, "What the Future Holds for Medicine," is being held March 26 - 29 at the Washington, DC, Hilton. Med Chi has made arrangements for physicians who are not able to attend the entire conference, but who would like to attend the Congressional Gatherings on Tuesday, March 28, from 6:30 p.m. to 10:00 p.m. Med Chi physicians may attend the Congressional Gatherings for a charge of $45. If you are interested in the Tuesday evening gatherings and/or the Wednesday visit to Capitol Hill, call Debbie Sciabarrasi at 410-539-0872 or 1-800-492-1056, ext. 303, for more information.

The dates and sites for future AMA National Leadership Conferences are as follows:

1996 — March 10 - 13 at the Renaissance Hotel, Washington, DC

1997 — March 16 - 19 at the Philadelphia, PA, Marriott Hotel (this meeting marks the sesquicentennial of the AMA).

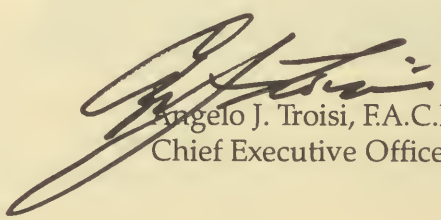
The National Leadership Conference offers physicians the opportunity to discuss legislative initiatives Congress is considering that will affect the practice of medicine and to visit their congressional representatives on Capitol Hill. For more information call Doris Konicki at the AMA, 312-464-5473.

AMA-YPS Community Service Award

The American Medical Association Young Physicians Section is accepting nominations for the 1995 AMA-YPS Community Service Award. The AMA-YPS represents physicians under age 40 who are no longer residents or fellows, or any age if within the first five years of professional practice. For a nomination form and additional information about selection criteria contact: AMA Department of Young Physician Services at 312-464-4749. Entries must be postmarked by April 1, 1995.

Free Immunization Information

An up-to-date packet of immunization information is available through a new AMA-staffed clearinghouse. It's free to all physicians, members and nonmembers. The project's expenses are funded through a grant from the Centers for Disease Control. To receive "Make sure they're covered" materials, call 1-800-621-8335 and ask for product number NCO15895.



Angelo J. Troisi, F.A.C.H.E.
Chief Executive Officer

197th Annual Meeting

Outcome Studies — Impact on Medical Practice

of the Medical and Chirurgical Faculty of Maryland

The Inn and Conference Center
University of Maryland
University College

Thursday, May 4, 1995
through
Saturday, May 6, 1995

Preliminary Agenda

General Information

Please note the information contained in this preliminary program is subject to change. More meetings, events, and continuing medical education activities may be added to the final program which will be distributed at the meeting.

Continuing Medical Education Credits

The Medical and Chirurgical Faculty of Maryland is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education (CME) for physicians.

The Medical and Chirurgical Faculty of Maryland designates this continuing medical education activity for up to 22.5 hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

Because some educational sessions will be presented concurrently, the maximum number of credits which can be earned by a physician attending this year's meeting is 12.5 CME credits.

Thanks

The Medical and Chirurgical Faculty of Maryland wishes to thank The Med Chi Insurance Agency, *Physician's Practice Digest*, Marion Merrell Dow, Inc. and The Upjohn Company for helping to support the annual meeting's continuing medical education program.

Directions

The Inn and Conference Center (formerly Adult Education Center) is located at the corner of University Boulevard and Adelphi Road in College Park, Maryland.

From Baltimore and points north:
Take I-95 South to the Capital Beltway (I-495) toward College Park. Take exit for U.S. 1 South (Exit 25B). Proceed approximately one mile south on U.S. 1 and turn right onto MD Rt. 193 West. At the third traffic light, turn left onto Adelphi Road. From Adelphi Road, make first, immediate left onto Campus Drive. The Conference Center will be visible on your left. The parking garage is located next to Conference Center.

From Bowie/Annapolis areas and points east:
Take MD Rt. 50 to Capital Beltway (I-95). Go north on I-95 to College Park. Take exit U.S. 1 South (Exit 25B). Proceed approximately one mile south on U.S. 1 and turn right onto MD Rt. 193 West. At the third traffic light, turn left onto Adelphi Road. From Adelphi Road, make first, immediate left onto Campus Drive. The Conference Center will be visible on your left. The parking garage is located next to Conference Center.

From Washington, D.C.:
Take George Washington Parkway to I-495 (toward Rockville). Follow I-495 and take the exit for New Hampshire Avenue/Takoma Park (Rt. 650). Go south on New Hampshire Avenue and turn left at the second light (Adelphi Road). Stay on Adelphi Road for approximately three miles (you will go through three traffic lights). At the fourth light, turn left on Campus Drive. The Conference Center will be visible on your left. The parking garage is located next to Conference Center.

From Montgomery County and points west:
Take the Capital Beltway (I-495) to New Hampshire Avenue/Takoma Park (650). Go south on New Hampshire and turn left at the second light (Adelphi Road.) Stay on Adelphi Road for approximately three miles (you will go through three traffic lights). At the fourth light, turn left on Campus Drive. The Conference Center will be visible on your left. The parking garage is located next to Conference Center.

Parking

A parking garage is located next to the Conference Center.

Parking is free for hotel guests and meeting attendees. Hotel guests should register at the hotel and receive their parking permit prior to parking in the garage. Meeting attendees who are not staying at the hotel must inform the garage attendant that they are with the Med Chi meeting. The attendant will then give you a dated hang tag which must be displayed in your vehicle while it is parked in the garage. Cars without hang tags will be ticketed!

Hotel Reservations

For room reservations at the Inn and Conference Center, please call 1-301-985-7310 or 1-800-727-8622 and indicate that you will be attending the Med Chi Annual Meeting. Special convention rates are $69 for a single room and $84 for a double room (and 8% tax). **Reservations must be made by April 14, 1995.**

Telephone Messages

During the meeting, messages can be relayed to participants via a message board located at the registration area. The number to call at the Inn and Conference Center is 301-985-7979 and ask for the Med Chi annual meeting desk.

▸ Miscellaneous

For questions regarding the meeting call 1-800-492-1056 or 1-410-539-0872:

- If your questions are about continuing medical education, call Joan Mannion, ext. 319; or
- For general questions about the annual meeting, call Vivian Smith, ext. 308 or Ruth Seaby, ext. 340.

▸ Support our Exhibitors

Visit the exhibits all day Thursday and Friday. Exhibits are an integral part of the Med Chi annual meeting and are a valuable adjunct to the scientific program.

During this year's annual meeting, Med Chi has allocated several specific time periods for physicians to meet one-on-one with exhibitors. By visiting exhibits, you will help ensure that Med Chi continues to receive valuable income that allows us to offer the annual and semiannual meetings.

Med Chi urges you to express your appreciation to exhibitors by visiting their booths and discussing your mutual involvement in patient care.

▸ 1995 Semiannual Meeting

Plan now to attend the Med Chi 1995 Semiannual meeting, Friday, September 8 to Sunday, September 10, 1995, at the Princess Royale Resort, Ocean City, Maryland. We hope to see you there!

▸ Thursday, May 4, 1995

Special Events

11:30 am - 12:30 pm

▸ Women in Medicine Luncheon

Join your women colleagues for a networking lunch. This luncheon is open to all women physicians, so invite your associates to attend. Cost is $15.00 and preregistration is required. See registration form.

6:00 pm - 7:00 pm

▸ Welcome Reception compliments of The Med Chi Insurance Agency

Relax with your colleagues and enjoy drinks and hors d'oeuvres compliments of The Med Chi Insurance Agency. Exhibits will be open during this event.

▸ Saturday, May 6, 1995

8:00 am - 9:30 am

▸ Practice Management Strategies for Young Physicians

Attend this special breakfast meeting compliments of *Physician's Practice Digest*.

Tickets are required to attend this breakfast and must be obtained in advance from the *Physician's Practice Digest* booth in the exhibit area.

No CME credit will be given for this lecture.

8:30 am - 9:30 am

▸ Innovative Concepts for Preserving Your Estate

Attend this special breakfast meeting compliments of the Med Chi Insurance Agency.

Tickets are required for this breakfast and must be obtained from the Med Chi Insurance Agency booth in the exhibit area.

No CME will be given for this lecture.

12:00 naan - 1:30 pm

▸ Maryland Medical Political Action Committee Luncheon Meeting (MMPAC)

Congressional Representatives Robert L. Ehrlich, Jr., Benjamin L. Cardin, Roscoe Bartlett, and Wayne Gilchrest have been invited.

All Med Chi members are encouraged to join MMPAC and attend the luncheon.

This luncheon is $5.00 for MMPAC members; nonmembers may join MMPAC by sending a check for $100 made payable to MMPAC, or may attend by paying $15.00 for the luncheon.

Preregistration is required for this lunch meeting. See registration form.

6:30 pm - 11:00 pm

▸ Presidential Banquet honoring J. Richard Lilly, MD

Black Tie Optianal

Enjoy dinner and dancing with music by the Zim Zemarel Orchestra. Cost is $60.00.

Thursday, May 4 1995

7:30 am - 5:00 pm

▸ Registration/Exhibits open

8:00 am - 10:00 am

▸ Back to the Essentials

Committee on Continuing Medical Education Review (CMERC)

Moderator: *Abdul Nayeem, MD,* Chair, CMERC

Speakers:

Abdul Nayeem, MD

The CMERC and You

Jack Mason, PhD, Dean, Continuing Medical Education, University of Maryland

What are the Essentials Anyway, and What's the Big Deal?

David Solomon, MD, Member, CMERC

CME: Turning Guidelines into Realities

Objectives:

Participating physicians will

- be able to describe the role, function and activities of the CMERC,
- be able to describe the essentials and their requirements, and
- be able to apply the requirements of the essentials to their CME program.

Target Audience: All physicians and administrative staff involved in planning CME activities

CME Credits: 2

8:00 am - 10:00 am

▸ Outcome Studies of Surgical Procedures — Impact on Medical Practice

Committee on Scientific Activity in cooperation with the Department of Surgical Oncology, University of Maryland

Introducer: *Benjamin V. Del Carmen, MD,* Committee on Scientific Activity

Moderator: *E. George Elias, MD, FACS,* President, Maryland Chapter of the American College of Surgeons

Speakers:

Aurelio Rodriguez, MD, FACS

New Horizons in the Evaluation of the Trauma Patient

J. Lawrence Fitzpatrick, MD, FACS

Peptic Ulcer: Medical/Surgical Management

Luis Queral, MD, FACS

The Effect of Endovascular Techniques in Vascular Surgery

E. George Elias, MD, FACS

National Surgical Adjuvant Breast Project: An Update

Objectives:

Participating physicians will be aware of

- advances in the management of trauma patients,
- advances in the treatment of peptic ulcer,
- advances in the treatment of vascular disease, and
- the most recent findings of the National Surgical Adjuvant Breast project.

Target Audience: Family practitioners, internists, surgeons

CME Credits: 2

9:00 am - 10:00 am

▸ Interferons and Cytokines: A Fourth Cancer Treatment Modality

Committee on Scientific Activity in cooperation with the University of Morylond Concer Center

Introducer: *Howard M. Silby, MD,* Member, Committee on Scientific Activity

Speaker:

Ernest C. Borden, MD, Director, University of Maryland Cancer Center

Objectives:

Participating physicians will be able to

- discuss the production, impact and clinical applications of interferons, hematopoietic growth factors, Interleukin-2 and other cytokines produced as a result of recombinant technology.

Target Audience: Family practitioners, internists and oncologists

CME Credit: 1

10:00 am - 10:30 am

▸ Break — Visit the Exhibits

10:30am - 11:30 am

▸ How Hard Is It to Immunize Teens Against Hepatitis?

Committee on Scientific Activity in cooperation with the Maryland Chapter of the American Academy of Pediatrics

Introducer: *Myron I. Murdock, MD,* Member, Committee on Scientific Activity

Speaker:

Crosson O'Donovan, MD, President, Maryland Chapter of the American Academy of Pediatrics

Objectives:

Participating physicians will be able to

- describe barriers to completion of the series of three immunizations for hepatitis in teenagers,
- identify risk factors in teenage patients who did not complete the series, and
- identify reminders that proved helpful, and those that did not prove helpful, in successfully completing the immunization series with this group.

Target Audience: Family practitioners, internists and pediatricians

CME Credit: 1

10:30 am - 11:30 am

▸ Hormone Replacement for the 90s

Committee on Scientific Activity

Introducer: *Howard M. Silby, MD,* Member, Committee on Scientific Activity

Speaker:
Harold T. Elberfeld, MD, Associate Director, Department of Obstetrics/ Gynecology, Franklin Square Hospital

Objectives:
Participating physicians will be able to describe
- what low-dose therapy involves,
- various regimens,
- the history of hormone replacement treatments (HRT), and
- benefits and risks of low-dose HRT.

Target Audience: Family physicians, primary care physicians, obstetricians/ gynecologists

CME Credit: 1

10:30 am - 11:30 am

▸ Three Dimensional Treatment Planning to Improve Care for Radiation Oncology Patients

Committee on Scientific Activity in cooperation with the Johns Hopkins Oncology Center

Introducer: *Henry N. Wagner, MD,* Chair, Committee on Scientific Activity

Speakers:
Lawrence Kleinberg, MD, Radiation Oncology Center, Johns Hopkins Hospital
Michael Herman, PhD, Radiation Oncology Center, Johns Hopkins Hospital

Objectives:
Participating physicians will be able to
- recognize patients appropriate for referral for three dimensional imaging,
- describe the use of a three dimensional radiation simulation device in planning radiation therapy which allows more precise delivery of radiation treatment, minimizing toxicity to healthy cells, and
- describe possible future applications.

Target Audience: Primary care physicians, oncologists, surgeons

CME Credit: 1

11:30 am - 12:30 pm

▸ Women in Medicine Luncheon

Preregistration and an additional fee are required to attend this luncheon. See page P-3 for details.

▸ Lunch on your own

12:30 pm - 1:00 pm

▸ House of Delegates Registration

All delegates and alternate delegates must register during this time and be seated by 1:00 pm when the meeting begins.

1:00 pm - 4:00 pm

▸ House of Delegates Meeting

4:00 pm - 4:30 pm

▸ Break — Visit the Exhibits

4:30 pm - 5:00 pm

▸ General Membership Meeting

5:00 pm - 6:00 pm

▸ Heroin and Other Opioids: Use and Abuse

Committee on Scientific Activity

Introducer: *Stanley R. Platman, MD,* Member, Committee on Scientific Activity

Speaker:
N. Joseph Gagliardi, MD, Family Physician, Columbia Medical Plan, and Medical Director of Addictions Services, Green Spring Mental Health Services

Objectives:
Participating physicians will be able to
- recognize signs and symptoms of opioid abuse and identify clinical procedures for diagnosing opioid abuse,
- describe treatment options for referring patients who are abusing opioids,
- identify practices for prescribing opioids responsibly, and
- recognize and resist patients who seek prescription drugs for abuse or illegal resale.

Target Audience: All physicians

CME Credit: 1

5:00 pm - 6:00 pm

▸ Photorefractive Keratectomy (PRK)

Committee on Scientific Activity in cooperation with the Morylond Society of Eye Physicians and Surgeons

Introducer: *James W. Karesh, MD,* Immediate Past President, Maryland Society of Eye Physicians and Surgeons

Speaker:
Gerri Goodman, MD, President, Maryland Society of Eye Physicians and Surgeons

Objectives:
Participating physicians will be able to describe
- photorefractive keratectomy (PRK),
- the results of clinical trials, and
- benefits and risks of PRK.

Target Audience: Ophthalmologists, family physicians, internists

CME Credit: 1

6:00 pm - 7:00 pm

▸ Welcome Reception

sponsored by the Med Chi Insurance Agency

Exhibits open during this reception. See page P-3 for details.

Friday

May 5

1995

7:00 am - 5:00 pm

- **Registration/Exhibits open**

8:00 am - 10:00 am

- **Suit Survival/Lessons in Risk Management**

Committee on Scientific Activity in cooperation with Medical Mutual Liability Insurance Society of Maryland

(Medical Mutual members who attend this session are eligible for a 5% premium discount on their 1996 medical professional liability renewal policy. A $40 program fee is required for this discount.)

Moderator: *Daniel Kohn, MD,* Staff Physician, Emergency Department, Harbor Hospital Center

Speakers:
Daniel Kohn, MD
Beth Petree, JD
Scott Sonntag, Esq.

Objectives:
Participating physicians will

- be able to identify current patient care issues as they relate to risk management concerns,
- understand risk management principles through examination of case studies of medical diagnostic and treatment options,
- understand the litigation process and how to deal with aspects of a lawsuit, and
- be able to discuss the application of risk management recommendations.

Target Audience: All physicians

CME Credits: 2

9:00 am - 12:00 noon

- **Reference Committees**

12:00 noon - 1:00 pm

- **Lunch on your own**

1:00 pm - 3:00 pm

- **Plenary Session — Harnessing the Winds of Change**

Committee on Scientific Activity

Introducer: *Donald H. Dembo, MD,* President, Medical and Chirurgical Faculty of Maryland

Keynote Speaker:
Lonnie Bristow, MD, President-elect, American Medical Association

Objectives:
Participating physicians will better understand

- federal and state legislative issues which affect the practice of medicine and managed care,
- educational issues, and
- the role of allied health professionals in patient care.

Target Audience: All physicians

CME Credits: 2



Dr. Bristow, an internist from San Pablo, California, was elected president-elect of the American Medical Association (AMA) in June 1994. A member of the AMA Board of Trustees since 1985, he has served as chair of the Board of Trustees from 1993 to 1994, as vice-chair from 1992-1993, and as a member of the Executive Committee since 1990. He represented the AMA as a commissioner to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) from 1990 to 1993, and his service on the AMA Education and Research Foundation includes serving first as its secretary-treasurer from 1986 to 1988, and then as its president from 1988 to 1990.

Before his election to the Board in June 1985, Dr. Bristow served as an alternate delegate and as a delegate to the AMA House of Delegates from the American Society of Internal Medicine. In 1979, he became a member of the AMA's Council on Medical Service, which he chaired from 1983 until his election to the Board of Trustees.

Dr. Bristow has long been active in organized medicine. Among the positions he has held are chair of the Section on Internal Medicine of the California Medical Association and president of the California Society of Internal Medicine and later, president of the American Society of Internal Medicine. He was also honored in 1977 by his election to membership in the Institute of Medicine of the National Academy of Sciences.

Dr. Bristow's service in the professional community has been and continues to be diverse as illustrated by his appointment to serve on the Institute of Medicine's Committee on the Effects of Medical Professional Liability of the Delivery of Maternal and Child Health Care from 1987 to 1989, his appointment by the Surgeon General to serve on the Federal Interagency Committee on Smoking and Health in 1988, and his appointment by the Secretary of Health and Human Services to serve on both the Center for Disease Control's HIV Prevention Advisory Committee and the 1989 Quadrennial Advisory Council on Social Security.

Born April 6, 1930, Dr. Bristow received his BS degree from the College of the City of New York in 1953 and his MD degree in 1957 from New York University College of Medicine. He completed his internship in 1958 at San Francisco City and County Hospital and served his residency in internal medicine at U.S.V.A. Hospital, San Francisco, Francis Delafield Hospital (Columbia University Service) New York City, and U.S.V.A. Hospital, Bronx, New York. In 1981 he completed an additional residency in occupational medicine at the University of California, San Francisco, School of Medicine. Dr. Bristow is a diplomate of the American Board of Internal Medicine and a fellow of the American College of Physicians. He is on the staff of Brookside Hospital, San Pablo, California.

Dr. Bristow has written and lectured extensively on medical sciences as well as on socioeconomic and ethical issues related to medicine. He currently serves as a reviewer for The Journal of the American Medial Association.

Dr. Bristow and his wife, Marilyn, reside in Walnut Creek, California, and are the parents of two children.

3:00 pm - 4:00 pm

▸ Break—Visit the Exhibits

3:00 pm - 4:00 pm

▸ Violence in the Emergency Department

Committee on Scientific Activity in cooperation with the Maryland Chapter, American College of Emergency Physicians

Introducer: *Daniel Kohn, MD, FACEP,* President, Maryland Chapter, American College of Emergency Physicians

Speaker:

Julie Ann P. Cassani, MD, MPH, FACEP, Director, The Johns Hopkins Hospital Advanced Life Support Transport; Assistant Professor, The Johns Hopkins University, School of Medicine

Objectives:

Participating physicians will

- become aware of what the current experience is with emergency department violence
- become familiar with what the potential experience of emergency department violence might be
- learn how to protect themselves, their patients and their emergency departments from incidents of violence.

Target Audience: Emergency physicians.

CME Credit: 1

4:00 pm - 6:00 pm

▸ The Clinical Application of Cardiovascular Research

Committee on Scientific Activity in cooperation with the American Heart Association, Maryland Affiliate

Moderator: *Stephen S. Gottlieb, MD,* University of Maryland School of Medicine

Speakers:

David Thiemann, MD, The Johns Hopkins University School of Medicine

The Effect of Outcomes Research on the Management of the Cardiac Patient

Peter Vaitkevicius, MD, Johns Hopkins Bayview Medical Center

Exercise and Heart Failure

Lawrence J. Appel, MD, MPH, Welch Center for Prevention, Epidemiology and Clinical Research

Potassium Supplementation as a Method of Preventing/Reducing High Blood Pressure

Roger S. Blumenthal, MD, The Johns Hopkins University School of Medicine

Results of the Scandinavian Simvastatin Survival Study

Objectives:

Participating physicians will be able to discuss

- recent breakthroughs in cardiovascular research,
- areas of research currently under investigation, and
- some clinical applications of recent research.

Target Audience: Family practitioners, obstetricians/gynecologists, cardio/thoracic surgeons, internists, pediatricians, preventive medicine specialists and public health physicians

CME Credits: 2

4:00 pm - 5:00 pm

▸ Recent Advances in Burn Care

Committee on Scientific Activity in cooperation with the Baltimore Regional Burn Center

Introducer: *Henry N. Wagner, MD,* Chair, Committee on Scientific Activity

Speaker:

Andrew M. Munster, MD, Director, Baltimore Regional Burn Center

Objectives:

Participating physicians will be able to describe

- recent improvements in burn care, particularly in the areas of triage, transportation, resuscitation, infection control and rehabilitation, and
- the methodology for studying burns outcome, in terms of mortality rates, utilization of resources and quality of life measurements.

Target Audience: Primary care physicians, ER physicians, and administrators.

CME Credit: 1

5:00 pm - 6:00 pm

▸ Common Mistakes in Emergency Department Management of Occupational Injury and Appropriate Use of an Occupational Medicine Clinic

Committee on Scientific Activity in cooperation with the Maryland Chapter, American College of Emergency Physicians

Introducer: *Jur T. Strobos, MD, JD, FACEP,* Director, Research Policy Staff, Office of Policy, Food and Drug Administration

Speaker:

Clifford S. Mitchell, MS, MD, MPH, Instructor, The Johns Hopkins University, School of Hygiene and Public Health

Objectives:

Participating physicians will

- better understand the legislation governing occupational health, including the 1970 OSHAct and Maryland regulations,
- become familiar with standards that can affect the initial assessment, management, and disposition of patients, including the Hazard Communication standard (Right to Know), and specific standards on particular hazards, and
- become aware of physician reporting requirements for certain occupational illnesses.

Target audience: Emergency physicians, occupational medicine physicians.

CME Credit: 1

Saturday

May 6

1995

7:30 am - 2:00 pm

▸ **Registration open (no exhibits)**

8:00 am - 9:30 am

▸ **Practice Management Strategies for Young Physicians**

Admission to this breakfast is by ticket only. Tickets must be obtained in advance from the *Physician's Practice Digest* booth in the exhibit area. Seating is limited to 25 people. This breakfast is compliments of *Physician's Practice Digest.*

Introducer: *M. Michael Massumi, MD,* Chair, Med Chi Committee on Young Physicians

Speakers:

Michael Hodes, Esq., Partner, Hodes, Pessin, and Katz

Charlotte Kohler, Principal, Kohler Health Care Consultants

This session will address practice start-up issues (e.g. negotiating strategies, business contracts, loan consolidation) and operational issues (e.g. leasing space, hiring personnel, marketing, referrals).

CME Credit: None

8:30 am - 9:30 am

▸ **Innovative Concepts for Preserving Your Estate**

Admission to this breakfast meeting is by ticket only. Tickets must be obtained in advance from the Med Chi Insurance Agency booth in the exhibit area. Seating is limited to 40 people.

CME Credit: None

9:30 am - 10:00

▸ **Public Health Update from the Secretary of Health and Mental Hygiene**

Introducer: *Henry Wagner, MD,* Chair, Committee on Scientific Activity

Speaker:

Martin Wasserman, MD, JD, Secretary of Health and Mental Hygiene

Objectives:

Participating physicians will

- be familiar with health initiatives undertaken in the first months of Governor Glendenning's administration, and
- health related legislation considered during the 1995 Maryland legislative session.

Target audience: All physicians

CME credit: 0.5

10:00 am - 11:00 am

▸ **Overview of Retinoids in Dermatology**

Committee on Scientific Activity in cooperation with the Maryland Dermatologic Society

Introducer: *Margaret Weiss, M.D,* President, Maryland Dermatologic Society

Speaker:

Gary L. Peck, MD, Director of Clinical Research, Department of Dermatology, Washington Hospital Center

Objectives:

Participating physicians will be able to describe

- the use of retinoids in the treatment of cystic acne, psoriasis and other dermatologic conditions, and
- the side effects of the retinoids.

Target Audience: Dermatologists, family practitioners

CME Credit: 1

10:00 am. - 12:00 noon

▸ **Production and Reproduction**

Committee on Scientific Activity in cooperation with the Asthma and Allergy Society of Maryland

Moderator: *John Bacon, MD,* President, Maryland Asthma and Allergy Society

Speakers:

Michael Blaiss, MD, Associate Professor of Pediatrics, Assistant Professor of Medicine, Director, Pediatric Allergy/Immunology Training Program, University of Tennessee, Memphis, Tennessee

The Role of Outcome Studies in Allergy and Clinical Immunology

Objectives:

Participating physicians will

- be able to identify specific outcome measures as they apply to allergic disease and asthma,
- understand the specific parameters and tools employed, and
- understand the medical/medico-economic implications of such studies.

Norbert Gleicher, MD, Director of Reproductive Immunology, The Center for Human Reproduction, President, The Foundation of Reproductive Medicine, Chicago, Illinois

Overview of Reproductive Immunology

Objectives:

Participating physicians will

- be able to discuss current concepts of reproductive immunology,
- be able to identify those factors that can contribute to reproductive failure, and
- be familiar with treatments being developed.

Target Audience: Family practitioners, internists, allergists, pulmonologists, pediatricians, endocrinologists, obstetricians/gynecologists

CME Credits: 2

10:00 am - 12:00 noon

▸ Physicians and the Tobacco Epidemic

Committee on Scientific Activity in cooperation with the Smoke Free Maryland Coalition

Introducer: *Martin Wasserman, MD, JD,* Secretary of Health and Mental Hygiene

Speakers:

W. Clinton McSherry, PhD, Clinical Research Fellow, Division of Pulmonary and Critical Care Medicine, The Johns Hopkins University School of Medicine

Treating Nicotine Addiction: The State of the Art and Beyond

Objectives:

Participating physicians will

- be able to describe the behavioral and psychological aspects of nicotine addiction, and
- be familiar with current and developing treatment options for nicotine addiction.

Rex D. Archer, II, MD, MPH, Health Officer for Garrett County, President, Maryland Association of County Health Officers

Preventing Addiction to Nicotine Before, During and After the Medical Visit

Objectives:

Participating physicians will

- be able to describe a range of creative approaches they can use, both in and out of the office, to prevent nicotine addiction in their patients, and
- be able to describe community level opportunities for preventing nicotine addiction.

Eva M. Smorzaniuk, MD, President, Talbot County Medical Society

Talbot County: A Case Study in Successful Physician Activism

Objectives:

Participating physicians will

- be able to describe how local physicians on Maryland's Eastern Shore fought the tobacco industry and won clean indoor air legislation for their county, and
- see and hear the pro-health messages developed and aired in this successful initiative.

Target Audience: All physicians

CME Credits: 2

12:00 pm - 1:30 pm

▸ Maryland Medical Political Action Committee Luncheon Meeting

Congressional Representatives Robert L. Ehrlich, Jr., Benjamin L. Cardin, Roscoe Bartlett, and Wayne Gilchrest have been invited.

Preregistration is required to attend this luncheon meeting. See page P-3 for details.

12:00 pm - 1:30 pm

▸ Lunch on your own

1:30 pm - 2:00 pm

▸ House of Delegates Registration

All delegates and alternate delegates must register during this time and be seated by 2:00 pm when the meeting begins.

2:00 pm - 5:00 pm

▸ House of Delegates Meeting

6:30 pm - 11:00 pm

▸ Presidential Banquet honoring J. Richard Lilly, MD

Black Tie Optional

Featuring:

Music by Zim Zemarel Orchestra

Preregistration and an additional fee are required to attend this function. See page P-3 for details.

Members of the Committee on Scientific Activity

Henry N. Wagner, MD, Chairperson

Benjamin V. Del Carmen, MD

Victor R. Hrehorovich, MD

Myron I. Murdock, MD

David A. Nagey, MD

Terrence P. O'Brien, MD

Stanley R. Platman, MD

Howard M. Silby, MD

Robert L. Yin, MD

Registration Form

Please Print Clearly:

Name _____

Address _____

City, State, Zip _____

Telephone _____

Component Society _____
(City, County)

Check all that apply

- **Scientific Session Registration**

  - ▷ Med Chi member — no charge
  - ▷ Preregistered nonmember — $100.00* _____
    **includes all CME presentations unless an additional charge is listed below.*

- **Event Preregistration** (See page P-3 for details on these events.)

- **Women in Medicine Luncheon**
  Thursday, May 4, 1995 11:30 am - 12:30 pm

  - ▷ I need _____ tickets at $15.00 each _____

- **MMPAC Luncheon**
  Saturday, May 6, 1995 12:00 noon - 1:30 pm

  - ▷ MMPAC Member — $5.00 _____
  - ▷ Non-MMPAC Member
    - ▷ I want to join MMPAC ($100 check made payable to *MMPAC* enclosed) _____
    - ▷ I wish to attend this luncheon only — $15.00 _____

- **Presidential Banquet**
  Saturday, May 6, 1995 6:30 pm - 11:00 pm

  - ▷ I need _____ tickets at $60.00 each _____

- **Total charges** _____

- **Babysitting Services**

  - ▷ Please check this triangle if you are interested in babysitting services and a form will be mailed to you.

Return this form with your check payable to "Med Chi" to:

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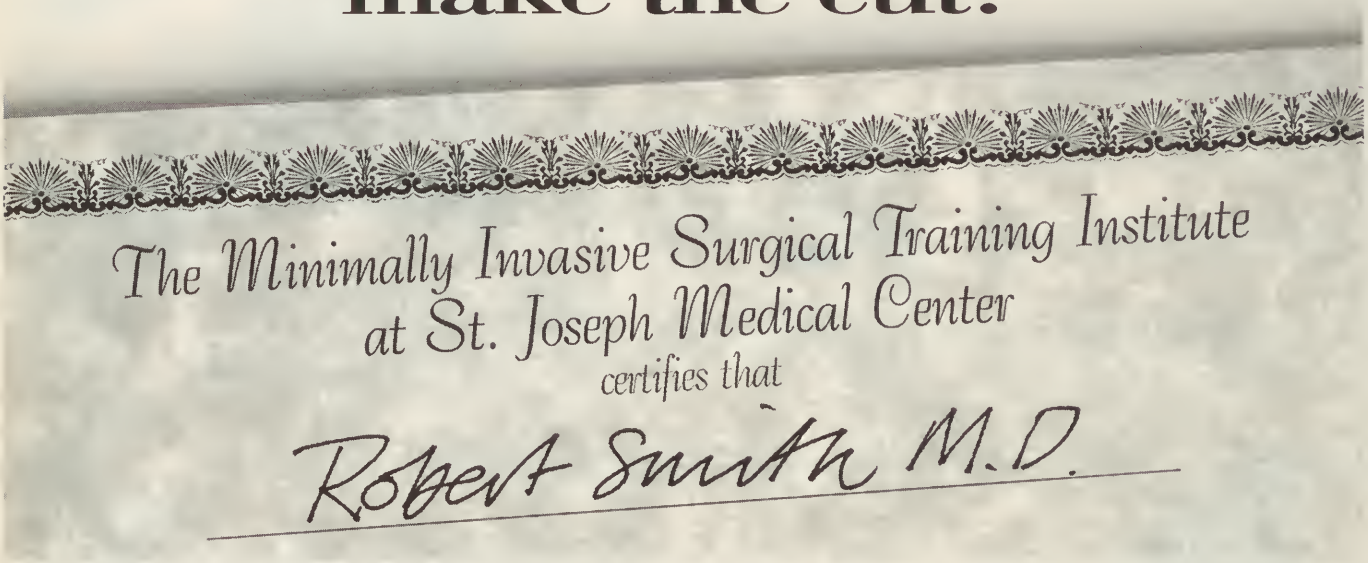
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Laparoscopic Anti-Reflux Surgery
May 12

Laparoscopic Colon Resection
March 21, April 14, June 9

Laparoscopic Hernia Repair
March 7

Laparoscopic or Thoracoscopic Spine Surgery
March 15, April 5, May 1, June 2

Lap-Assisted Vaginal Hysterectomy & Laparoscopic Supracervical Hysterectomy
March 28, April 25, May 30, June 27

Courses

Diagnostic and Operative Hysteroscopy
March 31

Laparoscopic and Thoracoscopic Spinal Surgery
April 7-8

Laparoscopic Anti-Reflux Surgery
May 19

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Members in the News



FRANK L. AYD, JR., M.D., L.F.A.P.A., professor of psychiatry at West Virginia University Medical Center and emeritus director of professional education and research at Taylor Manor Hospital, was honored by receiving one of two Lifetime Achievement Awards presented by the *Psychiatric Times* and Marion Merrell Dow at the November 1994 U.S. Psychiatric & Mental Health Congress in Washington, DC. A certified diplomate in psychiatry from the University of Maryland School of Medicine, Dr. Ayd is a world-renowned lecturer and educator. He is editor of the *International Drug Therapy Newsletter* and the *Medical-Moral Newsletter.* Author of *Lexicon of Psychiatry, Neurology, and the Neurosciences*, and *Recognizing the Depressed Patient*, Dr. Ayd has written hundreds of scientific articles, in addition to being the editor or coeditor for more than 10 books. Dr. Ayd has been honored by many organizations, including the American Medical Writers Association and the American College of Neuropsychopharmacology.



RICHARD BERKOWITZ, M.D., a board certified obstetrician/gynecologist attending at Church, Sinai, Franklin Square, and Harbor hospitals, was selected by the Baltimore City Medical Society to receive the 1994 Community Service Award for his work in support of Health Care for the Homeless. A graduate of Hahnemann Medical College in Philadelphia, Dr. Berkowitz completed his internship at Fitkin Memorial Hospital in New Jersey and his residency at Sinai Hospital in Baltimore. Dr. Berkowitz has served as a board member at Health Care for the Homeless for more than five years, the last two as vice president. He is a member of the American Fertility Society, the American College of Obstetricians and Gynecologists, the American Institute of Ultrasound in Medicine, and the American Association of Gynecological Laparoscopy.



MANUEL S. COCKBURN, M.D., a pathologist from La Plata, MD, recently received a three-year appointment as Cancer Liaison Physician for the Hospital Cancer Program at Physicians Memorial Hospital. Dr. Cockburn received his medical degree from the University of Madrid, Spain, and did his internship and residency at Providence Hospital in Washington, DC. Former chief of the medical staff at St. Mary's Hospital, Dr. Cockburn currently works as an associate physician/pathologist at the hospital. He is the former chief of the medical staff and the former director of quality assurance at Physicians Memorial Hospital. He is currently director of laboratory and pathology medicine at Physicians Memorial Hospital. A member of several medical societies, Dr. Cockburn is a fellow of the American College of Pathologists and the American Society of Clinical Pathologists.



RICK A. HOWARD, M.D., was recently named chief of anesthesia at Mercy Medical Center in Baltimore. Dr. Howard received his medical degree from Vanderbilt Medical School and interned at the University of Virginia. He completed his residency, as chief resident, and fellowship training in cardiothoracic, neurosurgical, and obstetric anesthesia at the University of Maryland School of Medicine. A diplomate of the American Board of Anesthesiology, Dr. Howard is the Quality Assurance Subcommittee chairperson and a member of the Critical Care Subcommittee at Mercy Medical Center. He is the author/coauthor of several scientific publications.



JAMES W. KARESH, M.D., an ophthalmologist from Baltimore, was recently elected president of the Maryland Society of Eye Physicians & Surgeons. Dr. Karesh received his medical degree from the University of Maryland School of Medicine and completed his internship in pediatric medicine at Children's Hospital National Medical Center in Washington, DC. Upon completion of his residency in ophthalmology at the University of Maryland School of Medicine, he held a fellowship in oculoplastic and reconstructive surgery at the Eye & Ear Infirmary, University of Illinois & Michael Reese Hospital and Medical Center in Chicago. An assistant professor in the department of ophthalmology at the University of Maryland School of Medicine and at the Wilmer Eye Institute of the Johns Hopkins Medical Institutions, Dr. Karesh is a medical staff associate at Sinai Hospital of Baltimore, Krieger Eye Institute, and an assistant clinical professor in the department of maxillofacial surgery at the University of Maryland School of Dentistry. In addition, he is director of oculoplastic surgery and chairperson of the Search and Departmental Committees at Sinai Hospital of Baltimore, Krieger Eye Institute, and director of the oculoplastic surgery and ocular oncology service, and ophthalmic plastic and reconstructive surgery at the University of Maryland School of Medicine. Dr. Karesh is a member of the editorial board of *Ophthalmic Plastic and Reconstructive Surgery* and has published 16 monographs and book chapters and over 50 scientific journal articles. A fellow of the American Academy of Ophthalmology and the American College of Surgeons, Dr. Karesh is a member of many professional societies.



MELVIN L. KELLER, M.D., former anesthesiologist-in-chief and medical director of Sinai Hospital's intensive care unit and respiratory care department, was appointed chairperson of the Medical Advisory Committee by RLT Medical Associates, Inc. A graduate of the University of Amsterdam Faculty of Medicine, Dr. Keller completed his medical internship at Brookdale Medical Center in Brooklyn, New York, and his anesthesiology residency at the U.S. Naval Hospital in Oakland, California. During his 40-year tenure at Sinai Hospital, he served on the patient care committee, was vice-chairperson of the medical executive committee, and chairperson of the cardiopulmonary resuscitation committee. Dr. Keller is the past chairperson of the Hospital Consultation Subcommittee of the Education Committee for the American Lung Association. A diplomate of the American Board of Anesthesiology and a fellow of the American College of Anesthesiologists, Dr. Keller is currently an assistant professor of anesthesiology and a clinical assistant professor of anesthesiology at the University of Maryland School of Medicine.



ROBERT C. LaMAR, M.D., a general practitioner in Snow Hill, MD, was recently honored by the Snow Hill Chamber of Commerce and other organizations for his half century of medical service. Dr. LaMar received his undergraduate degree from Goshen College in Goshen, Indiana, and his medical degree from the University of Maryland School of Medicine. He completed an internship at the U.S. Marine Hospital in Baltimore. Dr. LaMar works full time treating patients and visiting inmates at the Worcester County Jail. He still makes house calls.



WAYNE B. LEADBETTER, M.D., clinical assistant professor of orthopedic surgery at Georgetown University and clinical assistant professor of surgery at the Uniformed Services University of Health Sciences in Bethesda, was the keynote speaker for the Second Scandinavian Congress of Sports Medicine in Copenhagen, Denmark, last November. Dr. Leadbetter is a graduate of Creighton University Medical School, Omaha, Nebraska, and completed general surgical and orthopedic residency training at The

Johns Hopkins Hospital. A frequent lecturer on sports medicine topics, Dr. Leadbetter has received the AMA Billings Bronze Medal for Teaching Excellence and the State of Maryland Governor's Award for contributions to research and education. He is senior editor and workshop chairperson of the National Institutes of Health and American Orthopedic Society for Sports Medicine's sponsored publication *Sports-Induced Inflammation: Clinical and Basic Science Concepts.* Selected for the American Orthopedic Society for Sports Medicine Asian Traveling Fellowship, Dr. Leadbetter is a fellow of the American Academy of Orthopedic Surgeons and an elected member of the American College of Sports Medicine, the American Orthopedics Research Society, and the American College of Surgeons.



ALAN E. OSHINSKY, M.D., P.A., director of the Center for Snoring and Sleep Disorders in Baltimore, has been named director of the Mercy Sleep Diagnostic Center at Mercy Medical Center. A specialist in the diagnosis and treatment of snoring; nasal and sinus diseases; allergies; voice disorders; and pediatric ear, nose, throat diseases, Dr. Oshinsky received his medical degree from Central University of the Caribbean School of Medicine at Cayey Cayey, Puerto Rico. He completed his residency at the University of Maryland Medical Center in Baltimore and was named chief resident of the ear, nose, and throat department. A board certified ear, nose, and throat surgeon, Dr. Oshinsky is a member of the American Academy of Otolaryngology Head and Neck Surgery and past president of the Maryland Society of Otolaryngology Head and Neck Surgery. He is a member of the Mercy Medical Center operating room and Northwest Hospital quality assurance committees.



BERYL J. ROSENSTEIN, M.D., professor of pediatrics at The Johns Hopkins University School of Medicine, was recently named vice president for medical affairs at the Johns Hopkins Hospital and presented with the Cystic Fibrosis Foundation's Richard C. Talamo Distinguished Clinical Achievement award. Dr. Rosenstein received his medical degree from Tufts University in Boston and completed his residency at Hopkins Hospital. A fellow of the American Academy of Pediatrics Pulmonary Disease Section and diplomate of the American Board of Pediatrics, Dr. Rosenstein is member of several professional and scientific organizations, societies, and committees. Currently the director of the Cystic Fibrosis Center at Hopkins Hospital, he is the associate chairperson of the department of pediatrics, director of the pediatric referral service, and the principal investigator for a Children's Medical Services grant. He also oversees the Pediatric Network at Hopkins Hospital and has published over 100 scientific articles and book chapters.



RICHARD S. ROSS, M.D., dean emeritus of the medical faculty at The Johns Hopkins University School of Medicine, was named the 1994 recipient of the Abraham Flexner Award for Distinguished Service to Medical Education by the Association of American Medical Colleges. Dr. Ross received his medical degree from Harvard, where he was also a research fellow in physiology. He completed his internship and residency at the Osler Medical Service at Hopkins Hospital. Dr. Ross is a master of the American College of Physicians, a diplomate of the National Board of Medical Examiners and the Subspecialty Board on Cardiovascular Disease, and a fellow of the American College of Cardiology and the Royal Society of Medicine. An active member of numerous professional societies, Dr. Ross is a former president of both the American Heart Association and the Heart Association of Maryland. He has held many consultant appointments and

has served on the board of directors of many organizations, including the Stanley J. Sarnoff Endowment for Cardiovascular Science. Dr. Ross has held many editorial appointments and was an editor of numerous editions of *Principles and Practice of Medicine.*



MARVIN SCHNEIDER, M.D., an internist/gastroenterologist in Wheaton, was appointed by former Governor William Donald Schaefer to the Maryland Health Resources Planning Commission. One of two physicians who will serve four-year terms on the commission, he was sworn in as a member of the commission in early January. Board certified in internal medicine, Dr. Schneider received his medical degree from Howard University. He interned at D.C. General Hospital and served his residencies at D.C. General Hospital, the Veterans Administration Hospital, and the National Institutes of Health. Dr. Schneider is a fellow of the American College of Physicians and a clinical professor of medicine at the George Washington University College of Medicine. He is a former president of the medical staff and former chairperson of the department of medicine at Holy Cross Hospital. Also active in organized medicine, Dr. Schneider has served as a member and chairperson of numerous committees and boards at both the county and state level. He is past president of the Montgomery County Medical Society and a past Med Chi Council chairperson.



DENNIS M. SMITH, M.D., the senior attending physician in the department of medicine at St. Agnes Hospital in Baltimore, has been elected president of the St. Agnes medical staff. Dr. Smith received his medical degree from the University of Maryland School of Medicine. He served his internship and residency at St. Agnes Hospital and was chief resident in his last year. Following his residency, Dr. Smith was a fellow in pulmonary disease at Maryland School of Medicine. He is a member of several professional organizations, including the American Thoracic Society, American College of Chest Physicians, and American College of Physicians. Dr. Smith is a diplomate of the American Board of Internal Medicine and the Subspecialty of Pulmonary Disease.

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Speak Out

Risk, radon, and rationality

Fear of the unfamiliar is a powerful motivating force in society. (The "devil you know" is less fearsome.) A comprehensive article on household radon in this issue of the *Maryland Medical Journal* plays on this irrational fear of the unfamiliar. The public's association of radiation with nuclear explosions, Hiroshima, Nagasaki, and nuclear war spills over to fears—which may not be rational—of low-level "background" radiation.

The excess deaths of uranium miners in Colorado,[1] uranium workers in East Germany,[2] and tin miners in Yunan, China,[3] are associated with very high levels of radon exposure. These extra deaths also appear to be associated with high levels of smoking (personal observation). In fact, in East Germany, workers were provided with low-cost cigarettes as a "benefit."[2]

Evidence for nonoccupational, household exposure radon deaths is much weaker, and recent articles call into question the association of household radon with excessive rates of cancer. Yalow[4] points out that "the evidence for radon-associated lung cancer among nonsmokers in the home environment is very weak. Among nonsmoking miners, there has been no excess lung cancer in those exposed to less than 1,000 times the 70-year indoor levels that the Environmental Protection Agency (EPA) estimates would result in 1 to 5 lung cancer-related deaths among 100 persons so exposed."[5-7] In a recent *Lancet* article, Bowie[8] stated, "The indirect evidence linking low levels of radon exposure to lung cancer is insufficient to warrant the remedial action proposed."

Government's concern and action on exposure to radon, the "unfamiliar," is clearly out of proportion compared with its inaction in reducing smoking, "the familiar." Abelson,[9] in a lead editorial in *Science*, pointed out that the EPA exaggerates cancer risks by a large factor. The EPA has done a major disservice in setting radon standards while virtually ignoring tobacco as a major risk factor. The article on radon in this journal points out that the high rate of lung cancer in Anne Arundel County may well be due to high smoking rates there. It is not reasonable

Speak Out

for government to focus attention on low levels of household radon with small or nonexistent risks while doing essentially nothing to decrease the ready availability of tobacco with its clear-cut risk relationships to human mortality and morbidity.

TIMOTHY D. BAKER, M.D., M.P.H., PROFESSOR
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Speak Out is a *Maryland Medical Journal* department created to enable Med Chi members to voice their opinions, convictions, or feelings about medicine and related subjects in a more lengthy format than is normally afforded by a letter to the editor. Please send Speak Out submissions, as well as letters to the editor and manuscripts, to the Editor, *MMJ*, 1211 Cathedral Street, Baltimore, MD 21201-5585.

LETTERS TO THE EDITOR

Doubts about single-payer reform

I read with great interest Dr. Wayne C. Spiggle's letter to the editor on the subject of health system reform (*Maryland Medical Journal* November 1994). I am in absolute agreement as to the need for legislation, such as the American Medical Association's Patient Protection Act, which would afford physicians the opportunity to apply for participation in any insurance network with the assurance that they would be judged on the basis of their professional qualifications and the quality of care they delivered. The fate of such reforms is critical in ensuring continued clinical autonomy for physicians in the face of economic profiling by insurers.

Dr. Spiggle's endorsement of single-payer reform was interesting. However, I remain unconvinced that such an approach can deliver on the promises that have been made in its regard. I am particularly skeptical of claims that such a system would provide sufficient savings to cover the uninsured. The General Accounting Office analysis noted the different specialty mixes present in Canada and the United States, yet failed to control for that difference in its computation of potential savings. AMA data on nonphysician payroll expenses, which constituted most of the basis for the "savings" reported by the GAO, show substantial variation across specialties. In particular, nonphysician payroll expenses per self-employed physician are higher among nonprimary care physicians, such as surgeons and obstetricians/gynecologists, than among general and family practitioners, pediatricians, or general internists. It follows that a significant portion of the administrative savings reported by the GAO are due to the greater share of primary care physicians in Canada rather than the presence of a single payer. Finally, in assessing the relative strengths of the two systems, any remaining difference in administrative costs between the two countries would have to be weighed against the value of our more rapid technological advances and the value of patient choice.

As Dr. Spiggle suggested in his letter, some people believe that single-payer systems offer the only possible salvation for fee-for-service medicine. Nothing inherent in single-payer systems, however, precludes the imposition of managed care controls or necessitates the use of fee-for-service payment. In fact, the GAO study cited in Dr. Spiggle's letter concluded that "a reformed U.S. system should also retain and build upon the unique strengths of the existing structure of U.S. health care . . . such as health maintenance organizations."

Recent events in Canada provide real evidence that single payer and

Letters To The Editor

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managed care are not mutually exclusive. Articles in the *Medical Post* (October 4 and October 11, 1994) report a variety of developments driving payment in Canada away from its traditional fee-for-service basis. For example, a new contract between Ontario's health ministry and the 77 health service organizations operating in Canada is described as a blended system based on capitation with fee-for-service for some services, such as delivery, surgical assists, and anesthesia. In Saskatchewan, about 15% of physicians receive payment through means other than fee-for-service, including contracts, sessional payments (e.g., emergency room), salaries, and most recently, per capita arrangements. In addition, community health centers, which pay their physicians on a salary basis, also are on the rise in Canada, with four more scheduled to open next year. Finally, provincial and federal health ministers meeting recently called for an action plan for moving forward on the capitation model of payment for primary care physicians.

The *Medical Post* also noted that a critical argument used in convincing Canadian physicians to accept a salary or capitation rate is that fee-for-service does not adequately compensate physicians for certain types of work, such as advising patients on prevention or managing patients at home. At least one committee of the Saskatchewan Medical Association is taking a different approach: revise the fee-for-service payment system and codes to encourage these services.

Near the end of Dr. Spiggle's letter, he states that a growing number of medical organizations are giving single-payer their support. I will make only two observations in that regard. The first is that in a couple of instances, one being the American College of Physicians, such organizations subsequently found themselves having to effectively reverse their position.

The second is that a June 1994 survey of the state medical societies conducted by *AMNews* found no states favoring a national single-payer option for states under national reform. Finally, in November, voters in California rejected Proposition 186, that state's single-payer initiative, by a margin of more than two to one. In the current political environment, it is highly unlikely that efforts on behalf of single-payer reform will be met with any greater success elsewhere.

DONALD T. LEWERS, M.D.
Easton, Maryland ■

Erratum

In the article entitled "Health Resources Planning Commission regulation of ambulatory surgical care" (Everton AR. *Md Med J* 1995;2:125-128), the first sentence in the second-to-last paragraph should read, *Third, changes in the law should be "grandfathered."*

According to the *1994 HMO Performance Report* issued by the Group Health Association of America last December, there has been a fivefold increase in HMO enrollment during the past 14 years. Today, more than 50 million people are enrolled in HMOs, up by 5.3 million last year.

Physician-hospital organizations also are growing at a rapid rate. According to a survey released in January by the professional services firm Ernst & Young, of 189 PHOs surveyed, almost 75% were less than 25 months old and more than 50% were less than 12 months old. Although PHOs remain largely unregulated, that situation may change if the Internal Revenue Service decides to limit physician control in PHOs to 20%. In March, the AMA board will consider a proposal calling for 50% physician representation on PHO and integrated delivery system boards (*AMNews*, January 23-30, 1995).

Prognostic indicators for in vitro fertilization success

Santiago L. Padilla, M.D.

Dr. Padilla, a reproductive endocrinologist, is the director of the Fertility Center of Maryland in Baltimore.

ABSTRACT: *To examine possible prognostic indicators for success and multiple pregnancy in a free-standing in vitro fertilization program, a chart review study based on 160 oocyte retrievals was undertaken. Evaluated factors included the woman's age, diagnosis, baseline follicle-stimulating hormone levels, peak estradiol levels, estradiol patterns, cycle day of oocyte retrieval, oocyte quality, and number of embryos transferred. Factors associated with a higher pregnancy rate and a higher multiple pregnancy rate may include age less than or equal to 35; diagnosis of unexplained infertility; pattern A early estradiol response; oocyte retrieval on cycle day 16; 2 or fewer fractured oocytes at retrieval; and transfer of 4 or more embryos.*

Since the first successful birth by in vitro fertilization (IVF) more than a decade ago, it has become apparent that in IVF programs the success rate depends on several prognostic factors, such as age, estradiol (E_2) response, diagnosis, and baseline follicle-stimulating hormone (FSH) levels.[1-3] The transfer of multiple embryos also improves IVF success rate, but increases the chances that multiple gestation will occur.[4-6] National IVF statistics published in May 1993 showed a live birth rate per IVF cycle of 15%.[7] Age greater than 40 and presence of a male factor were poor prognostic signs in the national statistics.

The purpose of the current study was to evaluate the woman's age, diagnosis, ovarian stimulation protocol, baseline serum FSH levels, early E_2 patterns on the ovarian stimulation protocols, peak E_2 response, oocyte quality, number of embryos transferred, and embryo

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Table 1. Effect of woman's age on IVF pregnancy rate

Age (years)	≤ 35	36-39	≥40
• # Egg retrievals	108 (69%)	37 (23%)	13 (8%)
• # Embryo transfers (ET)	101	36	9
• Pregnancies (% retrieval)	40 (37%)[1]	7 (19%)[1]	2 (15%)[1]
• Pregnancies (% ET)	(40%)	(19%)	(22%)
• Miscarriages (%)	2	1	1
• Ongoing preg. rate/retrieval	38 (35%)[2]	6 (16%)[2]	1 (8%)[2]
• Ongoing preg. rate/ET	38%[3]	17%[3]	11%[3]
• Twins	9	1	-
• Triplets	6	-	-
• Implantation rate	16%[4]	6%[4]	6%[4]

[1,2,3,4] $p < 0.05$ by Fisher's exact test

cryopreservation as prognostic indicators for success and multiple pregnancy in a free-standing IVF program.

Materials and methods

From October 1, 1992, to March 1, 1994, 160 oocyte retrievals were performed for IVF at the Fertility Center of Maryland. Two patients who underwent oocyte retrieval had all the embyos cryopreserved because of a high risk of ovarian hyperstimulation and were excluded from the study.

All patients underwent a complete infertility evaluation with semen analysis, hysterosalpingogram, endometrial biopsy, postcoital testing, ovulation monitoring, and laparoscopy. The diagnosis of unexplained infertility was given to the couples that had a complete infertility evaluation that was normal, including ultrasound monitoring of follicular development and follicular rupture. Baseline serum FSH and luteinizing hormone (LH) levels were determined.

All patients underwent ovarian stimulation with a "flare-up" (FPL) or luteal phase (LPL) leuprolide acetate in combination with human menopausal gonadotropin (HMG) and pure FSH as described by Garcia et al.[8] The FPL protocol was started with leuprolide acetate on menstrual cycle day 2. The LPL protocol was started with leuprolide acetate on cycle day 18 to 20 after the serum progesterone level was greater than 3 ng/ml. Leuprolide acetate was given every morning subcutaneously at dosages of 0.75 mg for patients weighing less than 70 kilograms and 1 mg for those weighing more than 70 kilograms. Ovarian stimulation started with 75 IU of pure FSH and 1 ampule of HMG containing 75 IU of FSH and 75 IU of LH. The combination was given intramuscularly at 8 a.m. and 3 p.m. starting on cycle day 5 (FPL protocol) and on cycle days 2 through 10 (LPL protocol) if the E_2 level was less than 30 pg/ml. Blood samples were drawn daily for E_2 determination.

Pelvic ultrasound was performed daily after the E_2 levels were greater than 200 pg/ml. When the serum E_2 was greater than 270 pg/ml, that afternoon pure FSH injection was discontinued.

Table 2. Effect of diagnosis on IVF pregnancy rate

Diagnosis	Tubal	Endometriosis	Male Factor	Unexplained Infertility
• # Egg retrievals	77[1]	64[2]	40	9
• # Embryo transfers (ET)	69	61	32	8
• Pregnancies (% retrieval)	25 (32%)[3]	17 (27%)	6 (15%)[4]	6 (67%)[3,4]
• Pregnancies (% ET)	(36%)	(28%)	(19%)[4]	(75%)[4]
• Miscarriages (%)	3	1	-	-
• Ongoing preg. rate/retrieval	22 (29%)	16 (25%)	6 (15%)[4]	6 (67%)[4]
• Ongoing preg. rate/ET	32%	26%	19%	75%
• Twins	5 (23%)	3 (19%)	-	2 (33%)
• Triplets	3 (14%)	-	1 (17%)	2 (33%)
• Implantation rate	12%	10%	8%[4]	38%[4]

[1] 20 patients also had a male factor
[2] 11 patients also had a male factor
[3,4] $p < 0.05$, chi square

Ovarian stimulation continued with 75 IU of pure FSH and 1 ampule of HMG in the morning and 1 ampule of HMG in the afternoon until 2 follicles were greater than or equal to 11 mm. The following morning, pure FSH injection was stopped and the patient continued with 1 ampule of HMG in the morning and 1 in the afternoon until 2 follicles were at least 16 mm in size. That evening, 10,000 units of human chorionic gonadotropin (hCG) were administered intramuscularly when at least 2 follicles measured 16 mm in diameter.

Table 3. IVF pregnancy rate based on estradiol levels by day of hCG administration

Estradiol (pg/ml)	<500	500-999	1000-2500	>2500
• # Egg retrievals	2 (1%)	37 (23%)	83 (53%)	36 (23%)
• Pregnancies (% retrieval)	1 (50%)	8 (22%)	27 (33%)	13 (36%)
• Miscarriages (%)	0	-	4	-
• Ongoing preg. rate/retrieval	1 (50%)	8 (22%)	23 (28%)	13 (36%)
• Twins	-	2	5	3
• Triplets	-	2	2	2
• Implantation rate	14%	16%	12%	16%

p > 0.05

Follicular aspiration by transvaginal ultrasound guidance was carried out 35 to 36 hours after hCG administration. Oocytes were inseminated with 50,000 washed motile sperm per milliliter of media 4 to 26 hours after retrieval depending on the degree of maturation. The swim-up technique was used for sperm processing. In the event of male factor, 350,000 to 500,000 sperm were used for insemination. The culture media consisted of Ham's F-10 media (Gibco, Grand Island, New York) supplemented with heat inactivated fetal cord serum. One day after insemination, the cumulus was removed mechanically to look for the presence of pronuclei. If fertilization did not occur, the oocytes were re-inseminated. The embryo transfer (ET) was done 72 hours after oocyte retrieval. All patients who underwent ET received supplemental progesterone throughout the luteal phase.

The early E_2 response patterns (A, B, C, and D) are based on the E_2 response to leuprolide acetate by cycle day (CD) 5.[3] Pattern A shows a prompt E_2 elevation by menstrual CD 3, followed by a fall on CD 4. Pattern B shows a delayed E_2 elevation by CD 4, followed by a fall on CD 5 or 6. Pattern C shows persistent E_2 elevation through CD 5. Pattern D lacks a significant early E_2 response.

The embryo implantation rate was defined as the number of gestational sacs present in the uterus by transvaginal ultrasonographic evaluation divided by the total number of embryos transferred to the patient being evaluated. A statistical evaluation was performed by chi-square analysis and Fisher's exact test.

Results.

Woman's age. There was a significant drop in the pregnancy rate starting in patients older than 35. The embryo implantation rate also was significantly lower in the older age group. Fifteen of the 16 multiple pregnancies (94%) occurred in women aged 35 or younger. The oldest patient with triplets was 32 (see **Table 1**).

Diagnosis. The best pregnancy rate occurred in couples with unexplained infertility (UI). The rate was significantly higher compared to that in patients with tubal factor and male factor infertility. Tubal factor and endometriosis were associated with the second and third best pregnancy rates, respectively. Male factor was associated with the lowest pregnancy rate. The pregnancy rate in patients with endometriosis was not significantly different when compared to any of the other groups.

The embryo implantation rate was highest in the UI group and lowest in the male factor group; the difference was statistically significant. The highest number of multiple pregnancies occurred in the tubal factor group, but most of the patients had IVF for tubal factor as an indication. The incidence of multiple pregnancy was very high in the UI group: among 6 pregnancies there were 2 sets of twins and 2 sets of triplets. There were no triplets in patients with endometriosis (see **Table 2**).

Baseline FSH levels. Baseline FSH levels (measured by an enzyme immunoassay) > 15 mIU/ml were predictive of poor response. Baseline serum FSH levels were obtained on cycle day 2 on the FPL protocol. In most of the patients (97%), the FSH level was ≤ 11 mIU/ml. In five patients, the FSH level was > 15 mIU/ml and their cycles were canceled due to a poor response. Of five patients whose baseline FSH level was 12 to 15 mIU/ml, two have ongoing pregnancies with baseline FSH levels of 14 mIU/ml and 15 mIU/ml, respectively.

Table 4. IVF pregnancy rate based on leuprolide screening test patterns

E_2 pattern	A	B	C	D
• # Egg retrievals	89	19	3	17
• Pregnancies (% retrieval)	27 (30%)	6 (32%)	-	6 (35%)
• Miscarriages (%)	4	-	-	-
• Ongoing preg. rate/retrieval	23 (26%)	6 (32%)	-	6 (35%)
• Twins	5 (21%)	3 (50%)	-	2
• Triplets	5 (21%)	-	-	-
• Implantation rate	14%	15%	-	13%

p > 0.05

Peak estradiol levels. Patients were arbitrarily divided into four groups according to E_2 level. Although there was a trend toward a better pregnancy rate in patients with a peak E_2 level $\geq$ 2500 pg/ml, the difference did not reach statistical significance. There was also no difference in implantation rate. Analysis of the peak E_2 results for the FPL and LPL protocols showed a better pregnancy rate associated with higher peak E_2 levels in the FPL protocol, but it did not reach statistical significance. In the LPL protocol, the pregnancy rate was similar, but the numbers were small. Multiple pregnancies were evenly distributed between the groups; there were two sets of triplets in each group whose E_2 level exceeded 500 pg/ml (see **Table 3**).

Estradiol patterns. In a previous study, the early E_2 pattern of response on the FPL protocol was associated with IVF success.[6] In that series, pattern A was associated with a significantly better implantation rate than patterns B and D; pattern D was associated with a very poor success rate. We have since modified the protocol for treating pattern D patients by administering four ampules of FSH (Metrodin) and two ampules of FSH plus LH (Pergonal) daily. Evaluation of the results of the Lupron screening test on the FPL protocol showed no significant difference among patterns A, B, and D. In pattern C, there were no pregnancies from three retrievals. Although the implantation rate was very similar, 10 of the 15 multiple pregnancies occurred in pattern A patients, including 2 triplet pregnancies. In our original series, all high multiple pregnancies (e.g., triplets, quadruplets) occurred in pattern A patients. In the current series, five of the six sets of triplets occurred in pattern A patients; the other set occurred in the LPL protocol (see **Table 4**).

Cycle day of oocyte retrieval. On the LPL protocol, the first day of gonadotropin stimulation was arbitrarily considered cycle day 2 to make it equivalent to the FPL protocol, which started on cycle day 2. The earliest retrieval was performed on cycle day 13 and

Table 5. IVF pregnancy rate based on cycle day of oocyte retrieval

Cycle day	13	14	15	16	17	18	>18
• # Egg retrievals	24	30	36	30	21	14	4
• # Embryo transfers (ET)	24	28	33	28	19	11	4
• Pregnancies (% retrieval)	5 (21%)	87 (27%)	12 (33%)	12 (40%)	7 (33%)	4 (31%)	1 (25%)
• Pregnancies (% ET)	21%	29%	36%	43%	37%	36%	25%
• Miscarriages (%)	-	-	1	2	-	1	-
• Ongoing preg. rate/retrieval	5 (21%)	8 (27%)	11 (31%)	10 (33%)	7 (33%)	3 (23%)	1 (25%)
• Ongoing preg. rate/ET	21%	29%	33%	36%	37%	27%	25%
• Twins	2	1	1	5	1	-	-
• Triplets	-	1	2	1	1	1	-
• Implantation rate	7%[1]	10%[2]	15%	19%[1,2]	17%	13%	6%

[1] *p < 0.05*
[2] *p = 0.05*

Table 6. Effect of fractured zona oocytes on IVF pregnancy rate

# Fractured oocytes	0-2	>2
• # Egg retrievals	152	7
• # Embryo transfers (ET)	140	7
• Pregnancies (% retrieval)	49 (32%)	0 (0%)
• Pregnancies (% ET)	35%[1]	0 (0%)[1]
• Miscarriages (%)	4	-
• Ongoing preg. rate/retrieval	45 (30%)	0 (0%)
• Ongoing preg. rate/ET	32%	0 (0%)
• Twins	10	-
• Triplets	6	-
• Implantation rate	14%[1]	0%[1]

[1] $p < 0.05$ by Fisher's exact test

the latest on cycle day 20. The pregnancy rate described a bell curve with the peak occurring on cycle day 16. Although it did not reach statistical significance, the implantation rate was better on cycle day 16 than on cycle days 13 and 14. Multiple pregnancies were distributed between cycle days 13 and 18; 6 occurred in patients who underwent oocyte retrieval on cycle day 16 (see **Table 5**).

Oocyte quality. Atretic oocytes did not appear to affect the pregnancy rate, but more than 2 fractured zona oocytes appeared to have a significant negative affect on pregnancy rate (see **Table 6**).

Number of embryos transferred. **Table 7** shows the association between the pregnancy rate and the number of embryos transferred. The implantation rate differed significantly when 4 embryos were transferred compared to the transfer of 3 and more than 5 embryos. There was a significant difference in the clinical pregnancy rate among patients who had 4 or 5 embryos transferred fresh with cryopreservation of excess embryos when compared to patients who had 3 embryos transferred fresh with cryopreservation of excess embryos (see **Table 8**).

Table 7. Effect of the number of embryos transferred on IVF pregnancy rate

# Embryos transferred	1	2	3	4	5	>5
• # Embryo transfers (ET)	14	13	28	52	30	10
• Pregnancies (% ET)	2 (14%)	3 (23%)	6 (21%)	22 (42%)	13 (43%)	3 (30%)
• Miscarriages (%)	-	-	1	3	-	-
• Ongoing preg. rate/ET	2 (14%)	3 (23%)	5 (18%)	19 (36%)	13 (43%)	3 (30%)
• Twins	-	-	-	8	1	1
• Triplets	-	-	-	3	3	-
• Implantation rate	14%	12%	7%[1]	18%[1,2]	13%	7%[2]

[1,2] $p < 0.05$, chi square

Discussion.

One of the most difficult decisions in IVF programs is the number of embryos to be transferred fresh compared to the number to be cryopreserved. IVF is expensive and many couples have long-standing infertility. The financial and emotional burden of multiple pregnancy can be overwhelming for a young couple starting a family. On the other hand, some couples may be able to afford only one IVF attempt. Multiple gestations are associated with a high perinatal mortality rate and increased incidence of preterm labor, preeclampsia, fetal anomalies, and low birth weight.[9] The rate of multiple pregnancy depends on the number of embryos transferred. Although embryo cryopreservation has a good success rate, most IVF programs have a lower ongoing pregnancy rate per embryo transfer with frozen embryos. In addition, approximately 35% of cryopreserved embryos do not survive the freezing/thawing process.

Several investigators have compared single and multiple gestations. Hershlag and coworkers[10] compared 27 multiple to 88 singleton gestations and found that the only significant difference was the higher number of embryos transferred in the multiple gestation group. In a comparison of 10 multiple and 37 singleton gestations, el Khazen and associates[11] found that all multiple pregnancies were obtained after transferring 4 or more embryos. Nijs et al[12] found that transferring two embryos prevents multiple pregnancy and does not significantly compromise the pregnancy rate. Glock and colleagues,[13] comparing 94 multiple to 176 singleton gestations, reported that multiple pregnancy was associated with endometriosis, tubal factor infertility, high E_2 levels, high embryo quality, gonadotropin-releasing hormone (GnRH) protocols, and favorable E_2 patterns. Baseline FSH levels were not associated with multiple pregnancy. Muasher et al[1] reported that a base-

Table 8. Effect of cryopreservation on IVF pregnancy rate by number of embryos transferred

# Embryos transferred	2	3	4	5	>5
• # Transfers	13	28	52	30	10
• # Embryo cryopreservations	3 (23%)	15 (54%)	34 (65%)	14 (47%)	2 (20%)
• Pregnancy rate/ET	23%	21%	40%	43%	30%
• Pregnancy rate in patients with cryopreservation	67%	7%[1,2]	41%[1]	43%[2]	50%

[1,2] $p < 0.05$ by Fisher's exact test

line FSH level > 20 mIU/ml on cycle day 3 is associated with a poor prognosis.

Although the multiple pregnancy rate is reduced significantly by limiting the number of embryos transferred, of the patients in the current series who had 3, 4, or 5 embryos transferred, there were 26 single pregnancies. In patients older than 35, there was only one set of twins. Most of the twin and triplet pregnancies occurred in patients on the FPL protocol; it should be noted, however, that the FPL protocol is used in 81% of our patients. Although 15 of the 16 multiple pregnancies occurred in the FPL protocol, the embryo implantation rate was the same (see **Table 9**).

Our data suggest that transferring only two or three embryos may compromise the success rate in this subgroup of patients. There was a significant difference in pregnancy and implantation rates between the transfer of three embryos and four embryos. We also analyzed data on patients who underwent embryo transfer with cryopreservation of excess embryos. We found a significant difference in the pregnancy rate between those who had 3 embryos transferred fresh and 4 or 5 embryos transferred fresh in patients who had cryopreservation of excess embryos. Setting an arbitrary cap on the number of embryos transferred fresh may significantly compromise the success rate in patients with a poor prognosis for IVF success.

Table 9. Effect of ovarian stimulation protocol on IVF pregnancy rate

Protocol	FPL	LPL
• # Egg retrievals	128 (81%)	30 (19%)
• Pregnancies (% retrieval)	39 (30%)	10 (33%)
• Miscarriages (%)	4	-
• Ongoing preg. rate/retrieval	35 (27%)	10 (33%)
• Twins	10	-
• Triplets	5	1
• Implantation rate	14%	14%

Conclusion

Balancing pregnancy rate and multiple pregnancy rate in terms of the number of embryos transferred remains a difficult decision. Our data indicate that in couples with unexplained infertility there is an excellent implantation rate and an excellent prognosis for IVF pregnancy. However, this group of patients, especially if they are young, should be cautious in terms of the number of embryos that are transferred.

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ALTERNATIVES TO TRANSURETHRAL RESECTION OF THE PROSTATE

During the past several years, there has been increasing interest in the development of nonsurgical, minimally invasive procedures for treating the symptoms of benign prostatic hyperplasia (BPH). The standard treatment, transurethral resection of the prostate (TURP), is effective, but associated with considerable morbidity, including retrograde ejaculation in up to 90% of patients.[1-3] Hospitalization averages 5 days and up to 20% of patients may need a second operation within 5 to 10 years. Recently studied alternatives to TURP include drug therapies (e.g., finasteride, terazosin, prazosin hydrochloride), urethral stents, balloon dilation, and laser and thermal treatments.

A number of investigators have reported that visual laser ablation of the prostate (VLAP) is safe and effective. In a study involving 47 men (43 treated as outpatients), Malek and colleagues[4] described short-term results comparable to those achieved with TURP, but with less morbidity and shorter recovery time. They state that no published studies of VLAP have reported posttreatment urinary incontinence or impotence and that retrograde ejaculation has been reported in only 8% of patients. Improvement in obstructive symptoms is not immediate, however, and patients may require an indwelling Foley catheter for several days after the procedure and intermittent self-catheterization for a few weeks thereafter. Because no postoperative tissue specimen is obtained, the possibility of occult prostatic carcinoma must be investigated thoroughly before VLAP.

Although thermal treatments using temperatures up to 45° C have been associated with poor results, Schulman and Zlotta[5] at the University of Belgium have reported objective improvement in urinary flow in 78% of 20 patients treated with a catheter device that produces temperatures near 110° C. The outpatient procedure, transurethral needle ablation (TUNA), can be performed in approximately 30 minutes with only urethral jelly anesthesia and intravenous sedation. Gross hematuria occurred in one patient, who was hospitalized for 24 hours; mild hematuria occurred in the other 19 patients and dysuria occurred in all patients. Urinary retention lasting 2 to 21 days (mean, 8) occurred in 5 patients. There were no reports of urinary tract infection, impotence, or retrograde ejaculation. In the United States, the TUNA device remains investigational pending Food and Drug Administration approval. Despite the excellent preliminary results reported with VLAP and TUNA, long-term outcome data are needed, as well as comparisons with TURP.

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Radon exposure: a review of the public health risk in Anne Arundel County, Maryland

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ABSTRACT: *Long-term exposure to indoor radon may lead to an increased lifetime risk of lung cancer. Because millions of U.S. residential homes may have elevated radon levels, indoor radon exposure may pose a substantial public health threat. In Anne Arundel County (Maryland), a county-wide residential radon survey indicated that 82% of all residential radon readings in the survey were below Environmental Protection Agency remediation guidelines. Of the elevated indoor measurements, however, 94.4% were distributed in the southern portion of the county. These results are consistent with data compiled by the EPA and the U.S. Geologic Survey. Continued residential radon testing should be encouraged, especially in areas with elevated readings.*

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Radon, a naturally occurring, chemically inert gas that is ubiquitous in the environment, is a member of a radioactive chain of compounds resulting from the decay of uranium to lead. Although radon itself does not pose a significant health risk, its decay results in a series of short-lived radioactive products.[1] Also called radon daughters, these decay products may be deposited in the human respiratory tract if inhaled and result in damage to target cells in the tracheobronchial epithelium.[2] Exposure to these decay products has been associated with an increased risk of lung cancer in numerous epidemiological studies.[3-8]

Prolonged exposure to high levels of radon has been well documented as an industrial cause of lung cancer in underground miners, especially uranium miners.[8] Based on extrapolation from these occupational studies as well as complementary investigations in animals,[2] it has been postulated that radon concentrations found in certain residential settings

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also may result in a substantial lung cancer risk.[9-12] Extrapolation from occupational data, however, provides only indirect evidence of residential radon exposure. Direct information addressing the public health risk of residential radon exposure has been limited, although several major residential radon studies are currently being conducted worldwide.

Environmental studies completed to date have been the subject of continuing controversy and scientific debate. In some correlation studies, a positive association between lung cancer mortality and domestic radon exposure has been reported; in others, no relationship or a negative association has been found.[12] None of the correlation studies have adequately addressed individual characteristics and risk factors such as exposure to cigarette smoke or other relevant occupational exposures that have been associated with lung cancer. Although a positive association between residential radon exposure and lung cancer has been reported in several case-control studies,[13-15] the studies were limited by small sample sizes, inclusion of actual radon measurements in only a portion of the participants' homes, and failure to address in sufficient detail concomitant tobacco use and other pulmonary risk factors associated with lung cancer. Estimates of annual lung cancer mortality generated from these types of epidemiological studies vary widely, especially in studies completed in the United States.[1]

Despite continuing debate over the number of lung cancer deaths associated with domestic radon concentrations, the U.S. Environmental Protection Agency (EPA), the Centers for Disease Control and Prevention, the American Lung Association, and the American Medical Association agree with estimates that suggest radon causes thousands of preventable lung cancer deaths each year. The Surgeon General's office recently warned that indoor radon exposure is a leading cause of lung cancer in the United States, second only to tobacco use. Because millions of residential homes in the United States may have elevated radon concentrations, indoor radon exposure may pose a substantial public health threat.[16]

The State of Maryland established the Maryland Radon Task Force and completed a radon survey in 1989 to determine the extent of indoor radon exposure in each county of the state.[17] The survey was voluntary and nonrandom, which may have resulted in significant selection bias. In addition, specific estimates of elevated radon levels in Anne Arundel County were limited because less than 5% of the homes had been tested when the final report by the Radon Task Force was completed.[18]

In 1992, The Johns Hopkins University completed a comprehensive needs assessment of the public health problems facing Anne Arundel County.[18] The final report targeted the lack of any comprehensive sampling of residential radon levels in the county as a key environmental health issue.

Both the Radon Task Force and Hopkins studies encouraged Anne Arundel County to address the radon potential of the county and conduct additional testing of residential dwellings. In response, the Anne Arundel County Department of Health conducted a county-wide residential radon survey as part of its cancer prevention program "Learn to Live." This article summarizes the available literature on residential radon exposure and presents the results of the county's residential radon survey. It also assesses the potential public health risk to residents and provides information that may assist health care practitioners and environmental health specialists in developing appropriate control strategies.

Assessing the risk of indoor radon exposure

Two elements merit serious consideration in judging the health risk posed by indoor radon exposure.[1] First, the general population's exposure largely reflects time spent in homes where radon concentrations are generally lower than those encountered in high-risk occupational settings. Thus, lung cancer attributable to residential radon exposure predominantly results from relatively low levels of exposure over many hours per day.

Second, the number of homes considered to have unacceptable radon concentrations depends on the threshold level or limit selected. The EPA has established a multistage response that associates graded levels of exposure with various levels of urgency for remedial action. The EPA recommends remedial action at a baseline annual average level of 4 picocuries of radon per liter of air (4 pCi/L) in homes and public buildings. According to the EPA, if an individual is exposed to radon and radon decay products at this baseline level over a lifetime of 70 years, there is a 1% to 5% chance that the exposure will result in death from lung cancer.[19] Although the EPA baseline is considered the lowest level that can be practically achieved given present technology, it is not without risk. As a result of the uncertainty about what is a safe baseline, other private and governmental agencies concerned with indoor air quality have established baseline levels that range from 2 pCi/L to 8 pCi/L.[17] Thus, as the limit of acceptability changes, the number of homes exceeding the limit also changes.

Estimating lung cancer mortality caused by radon exposure

The EPA recently revised its estimates of annual cancer deaths associated with exposure to radon and radon progeny based on a new National Academy of Sciences study.[20] The number of radon-induced lung cancer deaths in the United States is now estimated by the EPA to range from 7000 to 30,000 per year with a central estimate of 14,000 deaths per year. According to one study, only 5% to 10% of these deaths are estimated to occur in nonsmokers.[8] Other evidence suggests that the interaction between radon decay products and environmental tobacco smoke causes an even greater lung cancer risk.[7]

The *Biological Effects of Ionizing Radiation (BEIR) IV* report suggests that the synergistic effects of radon exposure and tobacco smoke may create a ten-fold increased risk for lung cancer.[7] These estimates were based on the relationship of radioactive radon daughters and cigarette smoking in the development of lung cancer in uranium miners. For the 50 million smokers and their families in the United States, the additional lung cancer risk due to radon exposure may be significant. Anne Arundel County has a higher rate of mortality from lung cancer than other Maryland counties.[18] The synergistic relationship between radon and smoking may be particularly important in Anne Arundel County because one of four adult residents currently smokes cigarettes.

Residential radon levels in Anne Arundel County

In October 1992, a small, targeted survey was proposed to supplement available data on the extent of domestic radon exposure in Anne Arundel County. The objectives were to gather baseline data on indoor radon concentrations throughout the county and to provide guidelines to citizens in various areas of the county regarding the necessity or urgency of testing their homes for radon. Due to limited resources, the study was not intended to provide a comprehensive assessment of the presence of elevated levels of radon in the county. The survey techniques selected were intended to provide screening of the county for radon levels and to produce estimates of radon concentrations throughout the county at a reasonable cost.

Materials and methods

Survey participants were originally solicited from a base population of approximately 5000 Anne Arundel County Board of Education employees (educational, administrative, and maintenance staff members). A questionnaire that was included with a mass mailing to employees requested voluntary homeowner participation in a county-wide radon testing project. Staff members of the Anne Arundel County Department of Health received a similar mailing. The questionnaire requested information about housing characteristics (e.g., type of construction, number of floors, type of heating system, presence of a fireplace and/or a basement) and past indoor radon screening and remediation.

Participants were selected according to a residence criteria requiring that homes be located in pre-selected sites in order to obtain a county-wide sampling of radon concentrations. The county was divided into 36 geographic areas according to the grid system in the index to maps from ADC's Anne Arundel County, Maryland, street map book. Sites were selected to provide equal distribution of samples throughout each grid area, excluding waterways and non-residential buildings. Statistical consultants recommended a sample size of no less than 100 sites to produce statistically valid results.

Of the original population identified, 149 participants were selected based on the proximity of their homes to the pre-selected sites. Each participant was asked to complete a 4-day measurement of indoor radon concentrations under closed house conditions during the winter heating season of 1992. Each residence was screened using an EPA-approved activated charcoal adsorption kit from Air Check, Inc. Participants were asked to follow the EPA protocols included in the kit to insure reliable screening. The instructions emphasized the need to complete testing in the lowest livable area under closed conditions and to return the kits to the laboratory for prompt analysis.

Of the 149 radon kits distributed, 100 (67.1%) provided valid data. Data were excluded and considered invalid if participants failed to complete the information requested in the radon sampling kit or if tests were submitted for analysis after the study deadline. Based on these exclusion criteria, 92 residences were considered valid data points. To supplement the data, a second group of participants were solicited to participate in the survey during the same heating season. If no samples were provided for a pre-selected site from the original population, door-to-door solicitation was completed in that grid area following the same inclusion/exclusion criteria. Participants from an additional 50 residences were solicited, resulting in 20 (40%) supplementary data points added to the original pool of valid samples. Distribution of



Figure 1. Distribution of valid radon test sites in the Anne Arundel County radon survey. Each symbol may represent more than one valid test sample.

the final 112 valid test sites across the county is illustrated in **Figure 1**.

Results

Figure 2 summarizes the radon concentration levels from the county-wide survey and the results of the Maryland State Radon Task Force statewide survey completed in 1989, showing the percentage of residential dwellings in each study that fell within EPA multistage response guidelines. Approximately 82.4% of the county residences were below the baseline annual average level of 4 pCi/L; in the statewide survey, 75% of the homes were below the baseline. In the county, 17.6% of the residences surveyed were in the range of 4 to 20 pCi/L level, compared to 23% in the statewide survey. No residences in the county survey were in the 20 to 200 pCi/L range.

When the county residences that fell within the 4 to 20 pCi/L category were plotted, 17 of the 18 data points (94.4%) fell within the southern portion of Anne Arundel County (**Figure 3**). This pattern appears to support the findings of a recent radon potential estimate generated by the U.S. Geologic Survey (USGS) in cooperation with the EPA for the state of Maryland,[21] in which southern Anne Arundel County was categorized as high in radon potential based on high levels of radioactivity, high indoor radon concentrations, and significant exposure to geologic rock formations that contribute to high levels of radon. The northern portion of Anne Arundel County was designated as displaying a moderate to variable geologic radon potential.

The small number of data points with high radon concentrations in the county's survey limit the inferences that might be drawn from these data. Therefore, additional radon concentration readings from Anne Arundel County were obtained from the EPA Region III Radon Group. These readings, submitted through July 1993, represented 3,890 data points for indoor radon concentrations. The southern portion of the county represented 40.7% of the total radon readings submitted by the county during this surveillance period.

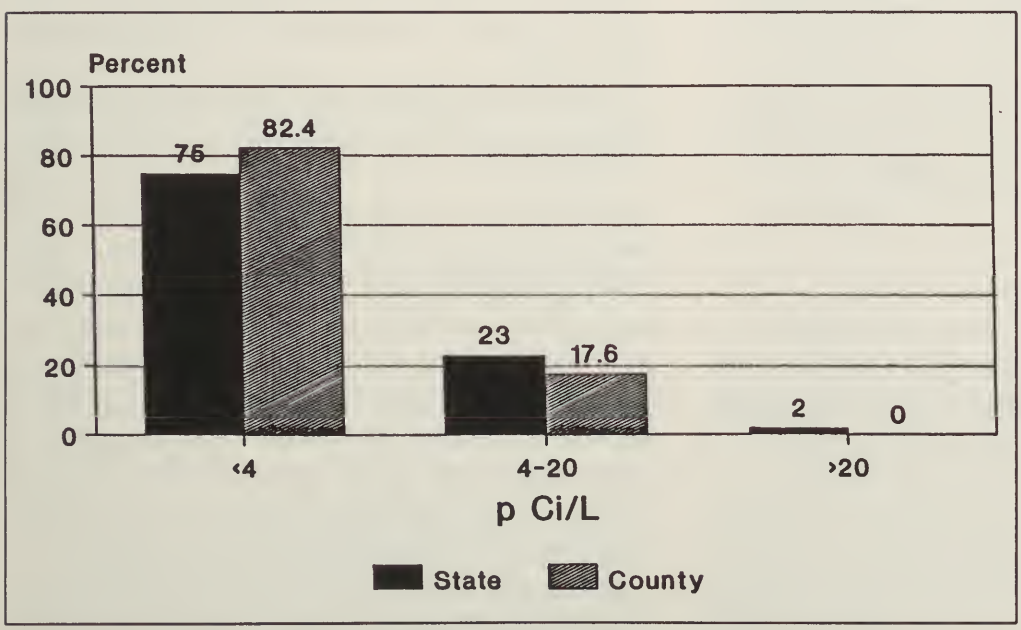


Figure 2. Indoor radon results of the Anne Arundel County radon survey (1993) and the Maryland Radon Task Force Survey (1989).

The EPA surveillance data indicated that the southern portion of the county represented more than 50% of the test results in every category in which the EPA recommends follow-up testing and possible remedial action (i.e., > 4 pCi/L). In some categories, the radon readings for the southern portion of the county represented over 85% of the elevated readings in that remedial action category.[22]

Discussion and conclusions

There are several reasons for cautious interpretation of the data in this study, including the possibility of selection bias. Nonrandom, voluntary samples may be biased toward overreporting (those who suspect their homes may have elevated radon levels may be more likely to participate). Educational and economic factors also may influence participation, leading to underrepresentation of certain housing unit types. Thus, the survey does not represent a random statistical survey and any conclusions drawn must consider this limitation.

In addition, the survey measurements represent concentrations from screening methods for indoor radon exposure that are often accompanied by a lower level of precision than other, more expensive detection methods. An inherent margin of error of plus or minus 25% is associated with the laboratory analyses used in this study; a reported reading of 4 pCi/L may in fact reflect a value as low as 3 pCi/L or as high as 5 pCi/L.

There are also major uncertainties and other potential sources of bias associated with exposure assessment estimates of any indoor radon investigation. First, collected data represent exposure that occurred over a very short period of time, resulting in incomplete cumulative exposure assessments. Second, major differences in housing construction, heating and ventilation systems, and occupants' activity also may result in inaccurate exposure estimates. For example, improved insulation and energy conservation techniques may increase the radon concentration in a residential dwelling, while conversion from forced hot air to hot water heating may decrease the radon concentration. Variations in the degree of ventilation and the presence of a fireplace also may result in measured concentrations that differ from actual exposure. Some occupants may spend more time in living areas with higher radon concentrations than others based on the architecture of the dwelling.[13]

The most significant limitation of this study is the small number of samples from the southern region of the county where the overwhelming number of elevated radon concentrations occurred. The small sample size limits the level of certainty of any conclusions and presents another potential source of bias.



Figure 3. Distribution of valid radon test sites falling within the remedial action level (4 to 20 pCi/L) advocated by the U.S. Environmental Protection Agency.

Despite these limitations, the study does characterize the southern region of the county as an area that may require an enhanced level of activity to encourage indoor radon testing relative to the northern portion of the county. Study data appear to be consistent with the findings of the comprehensive USGS/EPA radon potential assessment of Maryland.[21] However, the findings of this study need to be corroborated by additional residential testing in other Maryland counties that display high geologic radon potential. Supplemental testing across the state also would provide health officials with valuable information and guidance as to where resources should be targeted concerning radon testing, mitigation programs, and public education.

The importance of indoor radon testing for all residents of Anne Arundel County may be the most important recom-

Recommendations and sources of information

Local programs to control indoor radon exposure should be based on

- understanding the pattern of exposure and risk of disease associated with exposure;
- ability to measure radon exposure accurately;
- availability of effective techniques for preventing and mitigating radon exposure;
- costs of managing the risks of indoor radon exposure.

Although there is no national policy for the regulation of residential radon exposure, the EPA has taken the lead in developing guidelines. It has numerous publications for public health practitioners, homeowners, contractors, state and county public health officials, and agencies responsible for measuring and mitigating radon exposure. The U.S. Department of Energy is a major source of technical information concerning indoor radon research, including characterization of the exposure environment, assessment of radon exposure related to the public health risk, and the definition of the dose-response relationship of radon exposure. The state of Maryland is also actively involved in information dissemination, state testing services, cooperative research projects with the EPA, training courses, and outreach programs, including the statewide toll free radon hotline (1-800-872-3666).

mendation resulting from this study. Continued surveillance and expanded public education will provide the information necessary to address the complex public health issue of residential radon exposure and lung cancer mortality in the county.

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Molecular genetics in pediatric training: how much do we really know?

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ABSTRACT: *A questionnaire was designed to assess the degree of knowledge among 44 residents and medical students in a pediatric residency program about recent advances in medical genetics. The mean score was 40% (4 correct answers per individual). There were no significant differences among the groups. The mean number of correct responses to each question was 13, but topics that had been highly publicized, especially in the lay press, were associated with more correct answers. Among residents and medical students, knowledge of the exact genetic defects of inherited diseases and their implications at the molecular and clinical levels may be limited.*

Thirty years ago, the location of fewer than 100 human genes was known. Today, that number is approximately 4000 and increasing daily. One of the most important recent developments was the polymerase chain reaction (PCR).[1] The molecule of the year 1989[2] transformed the way molecular analysis is carried out in both research and clinical laboratories[3] and contributed to the birth of the Human Genome Initiative, the 15-year project intended to map and eventually sequence the 3.3 billion base pairs of the human DNA.

Most of the endeavors of molecular medicine concern diseases of children. Among the primary care specialties, pediatrics is the first to deal with issues such as fetal research; molecular diagnostics and treatment;[4,5] gene therapy of an immunodeficiency disorder, cystic fibrosis and leukemias;[6] and early diagnosis of the fragile X syndrome,[7,8] myotonic dystrophy,[9] cancer predisposition,[10,11] and possibly Huntington's disease.[12,13]

According to a recent survey, pediatric residents favor training in developmental and behavioral pediatrics,[14] a subspecialty deeply affected by new molecular diagnostic modalities. Results of another study indicate there may be no need for separate primary care and academic tracks in pediatric

training.[15] Thus, it seems imperative to integrate this new knowledge in general pediatric training. In our program, recent advances in molecular genetics are often emphasized in separate lectures, case presentations, and clinical rounds. It was our impression, however, that the rate at which new developments occur may exceed their incorporation in the curriculum for pediatric training. In addition, the nonmedical press may supplant the medical/scientific literature as the primary source of information for pediatric trainees. To test this hypothesis, we asked residents and medical students to answer questions on 10 recent developments in molecular medicine with significant impact on the science and practice of pediatrics.

Materials and methods

A total of 44 residents and medical students in the department of pediatrics at Georgetown University Hospital in Washington DC, participated in the study: 10 first-year (PGY-1), 9 second-year (PGY-2), 9 third-year (PGY-3) pediatric residents, and 16 medical students (MS) during their third or fourth year clinical rotation in pediatrics. A questionnaire consisting of 10 multiple-choice questions with 5 possible answers each was distributed to the participants during regular house-staff meetings and clinical rounds or case discussions. The questionnaire also asked the training level of the respondent and the year of medical school graduation. The completed, anonymous questionnaire was returned at the end of each session. All students and residents turned in their answers (response rate, 100%).

Survey questions are shown in **Table 1**. Three questions (definition of PCR, the nature of the p53 gene, and the diseases to which human gene replacement therapy has been applied) were on topics that had been highly publicized, especially in the lay press. Two questions (relationship of the N-myc oncogene with the prognosis of neuroblastoma[16] and the Prader-Willi syndrome as an example of uniparental disomy[17]) were on subjects widely reviewed in the recent pediatric and other medical literature. Four questions required more detailed knowledge of the exact molecular defect of a disease (the most frequent mutation causing cystic fibrosis,[18] the chromosomal localization of the neurofibromatosis genes,[19,20] and the mutations in fragile X syndrome[7,8] and myotonic dystrophy.[9,21] One question concerned the problems associated with enzyme replacement in Gaucher's disease.[22-24] Answers to all questions were easily found in the most recent medical literature.

Student's t-test was used to compare the mean scores of the four groups (PGY-1, PGY-2, PGY-3, and MS). The Bonferoni test was used to compare the mean scores and for analysis of variance. Finally, the chi-square test was used to evaluate differences across groups in the number of correct answers to specific questions.

Results

There were no significant differences in the number of correct answers among the four groups (**Table 1**). The mean score was 39.6% ± 17.1% (mean ± SD), i.e. approximately 4 correct answers per participant. Mean group scores are shown in **Table 2**.

Only 4 of the 28 residents (14.3%) and 1 of the 16 students (6.3%) had more than 7 correct answers; 20 residents (71.4%) and 10 students (62.5%) had 3 to 6 correct answers, and 4

Table 1. Survey questions, correct answers, and number of correct answers by group

Question	Correct Answer	Number of Correct Responses				
		MS (n=16)	PGY-1 (n=10)	PGY-2 (n=9)	PGY-3 (n=9)	TOTALS
1. Definition of PCR	DNA amplification	12	8	6	7	33
2. Exact genetic defect in CF	chrom.7, Δ_F508	0	1	2	1	4
3. Chromosomes for NF-I and -II	17 and 22, respectively	5	2	1	2	10
4. Nature of the p53 gene	tumor suppressor gene	11	4	4	3	22
5. Example of uniparental disomy	Prader-Willi syndrome	6	7	5	4	22
6. Exact genetic defect in FXS	triplet repeat mutation	2	3	2	1	8
7. Genetic defect in DM	as above, in chrom.19q	1	3	2	1	7
8. Oncogenes in NS	N-myc, prognostic factor	10	8	8	7	33
9. Treatment of Gaucher's	Enzyme repl., cost of Tx	3	1	1	2	7
10. Published gene Tx trials	ADD and CF	8	7	5	5	25

MS: medical students
PGY-1, -2, -3: postgraduate year 1, 2, 3
PCR: polymerase chain reaction
CF: cystic fibrosis
NF: neurofibromatosis
FXS: fragile X syndrome
DM: myotonic dystrophy
NS: neuroblastoma
gene Tx: gene replacement therapy
ADD: adenine deaminase deficiency.

Table 2. Mean group scores

Medical students	37.5% ± 18.8%
PGY-1	44% ± 17.1%
PGY-2	41.1% ± 14.5%
PGY-3	36.7% ± 18%

residents (14.3%) and 5 students (31%) had 1 to 2 correct answers.

Although the mean number of correct responses to each question was 13, there were significant differences among the number of correct answers to specific questions. There were 33 correct answers regarding PCR and the use of N-myc oncogene as a prognostic indicator for the clinical course of neuroblastoma ($p < 0.001$); 25 correct answers regarding diseases for which human gene replacement therapy results have been published ($p < 0.05$); and 22 correct answers regarding the nature of the p53 tumor suppressor gene and Prader-Willi syndrome as an example of uniparental disomy ($p < 0.05$).

On the other hand, only four residents and none of the students knew the exact mutation responsible for the majority of the cases of cystic fibrosis ($p < 0.05$). There were only seven correct answers regarding the cost of enzyme replacement in Gaucher's disease and the exact genetic defect in myotonic dystrophy. There were only eight correct answers for the exact genetic defect in fragile X syndrome.

It is noteworthy that 33 respondents, apparently confusing myotonic dystrophy with Duchenne's muscular dystrophy, answered that myotonic dystrophy is X-linked or that its gene is located on the same chromosome as fragile X syndrome. In addition, 22 respondents knew that the gene defect for cystic fibrosis is on chromosome 7, but they answered that the responsible genetic change is a deletion of the short arm of that chromosome. Nine residents and 6 students answered that fragile X syndrome does not affect female carriers; 18 respondents answered that enzyme replacement for Gaucher's disease has not been tried in humans (data not shown).

Discussion

Survey responses showed no significant differences in the degree of "molecular genetic awareness" among participants from four levels of medical training. Most study participants correctly answered questions on issues publicized in the lay press or that first appeared in the non-recent medical literature (e.g., PCR, the p53 tumor suppressor gene, and the human gene therapy trials). Many respondents correctly identified Prader-Willi syndrome as an example of uniparental disomy; although this was reported relatively recently[17] and uniparental disomy is not explained in current medical genetics textbooks, it has been extensively publicized in the lay press.[25] Questions on molecular advances already applicable in clinical practice (PCR, the N-myc oncogene, and neuroblastoma) also had a high number of correct answers.

On the other hand, despite being exposed to frequent references to molecular medicine during clinical rounds and lectures, respondents showed limited knowledge of the exact genetic defects of diseases such as cystic fibrosis, myotonic dystrophy, neurofibromatosis, and fragile X syndrome. Although the survey did not ask about the reading habits of study participants, it would appear that very few kept up with advances in molecular genetics as published in the general medical and pediatric literature.

The explosion of medical knowledge in recent years has made many medical journals inaccessible to students and residents.[26,27] At the same time, articles on medical topics appear every week in the lay press,[25,28] often before the scientific data appear in the medical literature (e.g., localization of the gene associated with the development of Huntington's disease[29,30]). Patients frequently learn about new diagnostic possibilities before the medical community becomes aware of them.[1] Although the current study did not address the question of whether residents and students use the nonmedical press as a significant source of information about advances in medicine, their rather superficial knowledge of molecular genetics suggests a positive answer.

Those responsible for medical schools and residency training programs around the country admit there is slow adaptation of training curricula to the rapid changes in medicine.[27] The universal applications of molecular medicine and the need for more and better trained primary care physicians[35] make it imperative that the new knowledge be integrated into medical training in a cohesive and comprehensive way.

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Friar Johann Gregor Mendel

Born to a peasant family in Moravia in 1822, Johann Gregor Mendel was a promising student who, as a young man, pursued an interest in both natural and agricultural sciences. When his family could no longer support his education, he became an Augustinian monk (1843) in order to continue his studies.

The early years of his professional career were characterized by a number of failures. His very first assignment as a clergyman, that of chaplain at a nearby hospital, was brief and unhappy. Then, despite his scholastic abilities, Mendel failed the qualifying examination that would have granted him a certificate to teach (1851). It is ironic that Mendel, whose name is known by every student of biology today, was never able to pass his teacher's examination and that his lowest score was in biology. Nevertheless, his superiors sent him to the University of Vienna (1851-1853), where, in addition to studying plant sciences and physics, he learned the fundamentals of statistics, numbers theory, and the laws of mathematical probability.

Mendel's interest in heredity was shared and supported by his abbot, and in 1854, Mendel began to grow and cross fertilize the common garden pea on his monastery grounds. Over a 10-year period, he grew thousands of pea plants of 34 different varieties, closely observing and recording the changes that occurred in successive generations of peas. His true genius lay in his ability to perceive the relationship between his studies in the garden and statistical probability.

Although the results of Mendel's studies were published in the *Proceedings of the Society of Natural Sciences* (1866), his work went unrecognized by the scientific community. When he died in 1884, he had no idea of the magnitude or significance of his studies, and all his data, notes, manuscripts, and scientific paraphernalia were promptly destroyed. It was not until the turn of the century that three botanists discovered and confirmed Mendel's findings.

It was soon promulgated that the physical basis of genetic inheritance is the same in all forms of life, from viruses to man. This proof of the oneness of life changed forever our understanding of the basic rules of the transfer of life from generation to generation. It is now universally accepted that heredity and genetics play a central role in sociology, anthropology, agriculture, animal sciences, medicine, and public health.

Friar Mendel would be pleased.

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Ewing's sarcoma presenting as an inguinal strain: case report

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Ewing's sarcoma occurs most often in young males and is the second most common tumor among teenagers. Primary tumors may occur anywhere, including extraskeletal or soft tissue locations. Case reports have documented sites in the jaw, occipital bone, ribs, and feet. In the early stages, symptoms may be very nonspecific and closely mimic common musculoskeletal complaints. Such presentations may lead to incorrect diagnoses and delay critical early workup, staging, and treatment. The following case report describes Ewing's sarcoma presenting with groin pain.

Case history

The patient, a 24-year-old white male, was initially seen for pain in the groin. He related the onset of his discomfort to getting out of a car. He gave a history of significant physical exercise, including cycling and weight-lifting with leg presses. Examination of the groin area, including the testicles, showed no abnormal physical findings; although the patient was tender directly over the groin muscles, there were no hernias or adenopathy. The provisional diagnosis was groin strain. Analgesic and anti-inflammatory agents were prescribed and the patient was instructed to return if his discomfort did not resolve.

One month later, the patient reported that his groin pain had improved significantly, but he complained of some discomfort in his left knee and hips and pain in the area of the left superior iliac crest. Physical examination again was unremarkable. There were no sensory or motor deficits. A complete blood count and erythrocyte sedimentation rate (ESR) were done; the ESR was 44 mm/h (elevated). An x-ray of the patient's left hip showed no abnormalities. The patient was instructed to return in one week.

A week later, the patient reported night sweats; pain in his knees, hips, and both sides of his groin; and pain radiating in both legs. He was



Figure 1. MRI shows involvement of the left illiac wing

afebrile and results of laboratory studies (antideoxyribonuclear protein, rheumatoid factor, streptococcal enzyme screen, mononucleosis, Lyme disease antibodies, and antinuclear antibody) were negative. Analgesics were again prescribed and consultation with an internist was requested. The internist ordered a magnetic resonance image (MRI) of the lumbosacral spine, which showed low-signal material posterior to the L-5 and S-1 disc spaces centrally and to the left of midline. The internist's diagnosis was lumbosacral disc disease, for which conservative therapy (heat, rest, and anti-inflammatory agents) was recommended. The patient's symptoms, however, did not respond to the treatment.

An orthopedic consultation resulted in clinical diagnoses of avascular necrosis of the left femoral head and inflammatory arthritis. However, a 3- to 4-beat ankle clonus was noted and an MRI of the pelvis was obtained. The MRI showed multiple lesions involving the neck of the right femur, left femur, left iliac wing, and iliopsoas muscle (**Figure 1**). A prebiopsy computed tomography (CT) scan with contrast of the pelvis showed no abnormalities except for a lucent line running across the roof of the left acetabulum that suggested a fracture. Bone biopsy confirmed Ewing's sarcoma. Bone scan showed increased uptake of radionuclide in both iliac wings, femoral heads, and the distal aspect of the right femur (**Figure 2**). The patient was treated initially with chemotherapy and is currently awaiting autologous stem-cell transplant. He is clinically stable, but not free from disease.

Discussion

Making the initial diagnosis of Ewing's sarcoma can be challenging.[1] Patients may present with nocturnal fever spikes and anorexia with associated weight loss. The most common symptoms are local pain and swelling in the affected area.[2] A history of trauma is often reported.[3] The long bones of the extremities are the most frequent sites of involvement, particularly the femur, tibia, fibula, and humerus.

One study showed the average time from onset of symptoms to diagnosis is 72 days.[4] The differential diagnosis includes avascular boney necrosis, osteomyelitis, and other musculoskeletal strains and traumatic conditions.

Research into the etiology of Ewing's sarcoma has focused on gene encoding, chromosomal rearrangement, and oncogene conversion.[5,6] Investigations of behavioral, occupational, and environmental factors have produced conflicting data.[7,8]

Ewing's sarcoma often responds to multidrug chemotherapy that may include various combinations of cyclophosphamide, doxorubicin, vincristine, actinomycin, etoposide, and ifosfamide; bleomycin, DTIC, methotrexate, carmustine, cisplatin, or 5-fluorouracil may also be included in some regimens. Although treatment is toxic and requires close supervision, multidrug therapy can cure even



Figure 2. Bone scan demonstrates the distribution of the bone involvement

metastatic disease in perhaps 25% of cases.[2] Additional management may include radiation therapy, resection, and bone marrow transplantation.

Because Ewing's sarcoma usually occurs in a young, active, healthy population group and initial symptoms often mimic those of common, benign musculoskeletal conditions, diagnosis may be delayed. When presenting symptoms persist longer than expected or fail to respond to conventional treatments, additional diagnostic considerations such as Ewing's sarcoma should be entered into the clinical equation.

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FINDING HELP FOR PATIENTS WITH DISABILITIES

Data compiled by the American Medical Association indicate that

- 49 million Americans have ongoing disabling conditions;
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- approximately 80% of the elderly have a chronic condition and in about 40% the chronic condition causes some form of activity limitation;
- 3.1% of those under age 18 have a physical, mental, or emotional disability;
- disability-related costs to the nation total more than $170 billion per year;
- 35% of Americans with serious illness, injury, or birth defects do not receive medical rehabilitation treatment.

In 1993, the AMA convened focus groups comprising consumers and allied health professionals to discuss barriers faced by physicians and disabled patients when dealing with assistive technology. The result was an AMA publication entitled *Guidelines for the Use of Assistive Technology: Evaluation, Referral, Prescription.* It is a quick reference and resource to help primary care physicians meet the needs of their disabled patients. Arranged in easy-to-comprehend outline form, topics include the role of the physician; the physician-patient relationship; patient assessment; individual roles, team concept, and the rehabilitation process; office practice guidelines; obtaining funding; and resources. Single copies are available for $5 from the Department of Geriatric Health, American Medical Association, 515 North State Street, Chicago, IL 60610.

In Maryland, information on assistive technology resources is available through the Governor's Office for Individuals with Disabilities, 300 W. Lexington St., Box 10, Baltimore 21201 (410-333-4975).

Vignette of medical history: Horatio Gates Jameson, M.D.

Joseph M. Miller, M.D.

Dr. Miller is a retired surgeon in Timonium, Maryland.

Intelligence and determination were the guiding forces in the life of Horatio Gates Jameson, M.D. (1788-1855), one of the shining lights of the Medical and Chirurgical Faculty of Maryland in the early years of the nineteenth century. Born in York, Pennsylvania, Horatio was a pupil of his father, David Jameson, M.D. He began medical practice at the age of 17 and then went to Wheeling, West Virginia, from 1799 to 1803. Returning to Pennsylvania, he attended lectures in Baltimore, Maryland, where he settled in 1810. Obtaining a medical degree from the University of Maryland in 1813, he thereafter practiced surgery at hospitals in the city and was considered one of the most able surgeons of his day. He was Physician to the Jail and Consulting Physician to the Board of Health.[1]

Jameson was a born teacher, but was denied the opportunity to assume a place on the faculty at Maryland. He then conceived the idea of organizing a new medical school in Baltimore. Such a step was considered proper as Baltimore was prosperous and had considerable growth potential. In addition, an intramural conflict at Maryland provided a further stimulus for the creation of another medical school.

With other physicians, Jameson applied for a state charter, but the request was denied. He then turned to Washington College, a small liberal arts school in Washington, Pennsylvania.[2] In the winter of 1825-1826, he was granted authorization to establish a medical school in Baltimore under the aegis of Washington College. A nominal situation existed between the two schools.

A second attempt to gain a charter from Maryland was successful when the Maryland legislature passed the act of incorporation in 1832 (the charter, however, bears the date March 3, 1833). The Washington Medical College requested a subsequent charter in 1839 that permitted it to change its name to the Washington University School of Medicine of Baltimore.

Section 1. *Be it enacted by the General Assembly of Maryland,* That a Medical college be, and the same is hereby established in the city of Baltimore, by the name of "The Washington Medical College of Baltimore," upon the following fundamental principles: The said College shall be founded and maintained upon the most liberal plan, for the benefit of students of every country and every religious denomination, who shall be freely admitted to equal advantages and privileges of education, and to all the honors of the College, according to their merit, without requiring or enforcing any religious or civil test, or urging their attendance upon any particular religious worship or service, nor shall any preference be given in the choice of a President, Professor, Lecturer, or other officer of said College, on account of his particular religious profession, but regard shall be solely paid to his moral character, and other necessary qualifications for the place for which he may be chosen.

Sec. 2. *And be it enacted,* That the following named persons be and they are hereby constituted professors of said College, to wit: Horatio G. Jameson, M.D., professor of Surgery and Surgical Anatomy; Samuel K. Jennings, M.D., professor of Materia Medica and Therapeutics; William W. Handy, M.D., professor of Obstetrics and the diseases of women and children; Thomas E. Bond, M.D., professor of the theory and practice of Medicine; Samuel Annan, M.D., professor of Anatomy and Physiology, and James B. Rogers, M.D., professor of Chemistry.

Sec. 3. *And be it enacted,* That the said Professors and their successors shall be, and they are hereby declared to be, one community, corporation, and body politic, to have continuance forever, by the name of "The Washington Medical College of Baltimore."

Excerpt from "An act Incorporating the Washington Medical College of Baltimore," *Laws of Maryland,* 1832, Chapter 189.

Dr. Jameson was professor of surgery and surgical anatomy at the school from 1827 to 1835. In the surgical portion of the curriculum, he endeavored to make the course practical. Abundant use was made of models, drawings, simulations of disease, and treatment of disease and injury as seen on the wards. Due attention was given to surgical pathological specimens. Various operative procedures were performed on cadavers and patients to teach students.



Horatio G. Jameson, M.D. (*courtesy of the Medical and Chirurgical Faculty of Maryland*)

In 1835, Dr. Jameson became the first president and professor of surgery at the Ohio Medical College in Cincinnati. He returned to Baltimore in 1836 and moved to York in 1854. It is curious that during this stay in Baltimore, he did not rejoin his former faculty.

In addition to being an excellent surgeon and a prime mover in the administration of the medical school, Jameson was a prolific writer. In 1829, he founded the *Maryland Medical Recorder* and served as its editor until 1832, when the journal ceased publication. Jameson wrote much of the material in the journal, although other college members contributed. In his articles, Jameson frequently examined pertinent foreign medical contributions and presented a critical analysis for readers along with his own thoughts on the subject. He also wrote four books: *Lectures on Fevers, American Domestic Medicine, Yellow Fever,* and *A Treatise on Cholera.*

Like many in the medical profession, Horatio Jameson was not only the son of a physician, but had a son who became a physician. Following in Horatio's footsteps, Rush Jameson attended the University of Maryland, where he received his medical degree in 1827 as the gold medalist of his class. In 1836, he entered the service of the Republic of Texas as a surgeon, but died there later in the year.

Horatio Jameson was an esteemed surgeon, physician, and author. The school he helped establish taught men to practice medicine in its broadest possible sense. For the period in which he lived, Jameson influenced positively a number of his fellow practitioners and a large number of medical students. Early Baltimore owes much to this inspiring example of a scholarly medical man.

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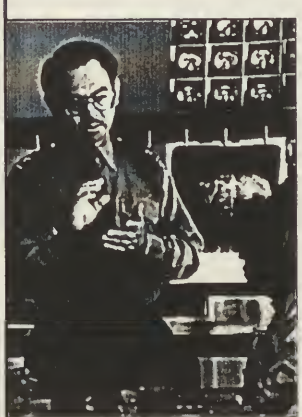


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Geriatrics for the Clinician

HYDRATION AND ALIMENTATION IN TERMINAL PATIENTS: A HOSPICE APPROACH

The final stages of chronic or terminal illness may be met with mixed emotions and many questions by patients, their loved ones, and their health care providers. After a period in our culture when death and the dying process have been removed further from patients' homes and their families' personal experiences, we are now finding increased involvement of families and other caregivers in the care of the dying. Although concern about ethical and legal issues often complicates matters, the goal of achieving a comfortable and dignified death is generally agreed upon.

Dying patients have many needs. In addressing the psychological and emotional needs as well as the control of pain, nausea, dyspnea, and other common symptoms of dying patients, physicians often need to rethink some of their most common practices. The provision of fluids and nutrition for dying patients is one of these practices. While returning to a more "natural" process, we now have increasing clinical and scientific data to reassure us that treating mouth dryness, but not providing fluids, electrolytes, or nutrients, provides the most comfort to terminally ill patients.

In contrast to the practice of most physicians who work in hospital settings where it often seems difficult to justify inpatient care without an intravenous catheter, hospice nurses are experienced in providing care for dying patients at home without intravenous hydration. A number of studies in these settings have confirmed increased comfort and even less need for pain medication in patients with terminal dehydration.[1-3] In case reports of individuals who either refused hydration, or for whom it was not thought to be in their best interest, peaceful, comfortable deaths are described. In fact, anecdotal reports suggest less patient discomfort from secretions and coughing, nausea and vomiting, urination, pulmonary and peripheral edema, and diarrhea when fluids are not given intravenously or by nasogastric tubes.[4]

A recent study of 32 terminally ill, competent patients admitted to a comfort care unit confirms these anecdotal reports.[5] Study patients were limited to food and fluids which they requested. A multidisciplinary team then questioned the patients and their families about symptoms and levels of comfort. Most patients experienced hunger or thirst only initially or not at all. In all patients, symptoms of hunger, thirst, and dry mouth could be alleviated with small amounts of food, fluids, ice chips, and lubrication to the lips and mouth. Some of the possible physiologic explanations for the lack of discomfort from protein-calorie malnutrition and eventual dehydration seen in these patients include the euphoria sometimes induced by fasts, analgesia produced by ketone bodies, and opioid production in the hypothalamus.

Studies of fluid and electrolyte status in terminally ill individuals demonstrate that generally expected imbalances and the symptoms associated with them are not common in terminal dehydration.[6,7] The discomfort of dry mouth again is noted to be treatable by maintaining moisture through sips of water, ice chips, or artificial saliva. Whereas it is difficult and perhaps ethically questionable to determine the precise physiologic responses to food and water deprivation in humans at the end of life, clinical studies verifying comfort in such patients and reasonable hypotheses to support such observations may be enough evidence for physicians and families to reconsider the impulse to supplement a dying patient's oral intake.

Fear of legal repercussions or ethical uncertainty might deter some physicians from recommending the withdrawal or withholding of fluids and nutrition from dying patients. By weighing the burdens and benefits of this intervention, a physician can ethically recommend such treatment and can institute it with the agreement of the informed patient or patient's surrogate.[8] Based on these principles of

medical ethics, most legal decisions allow for the withdrawing or withholding of hydration and nutrition.[3]

Caring for the dying patient can be demanding both personally and professionally. The expertise of hospice nurses and other health care workers can benefit anyone who takes care of dying patients. A team-oriented approach to these patients can be especially rewarding for all. Last year, the 36 hospice programs in Maryland cared for more than 5300 patients. In general, palliative care is provided to those with life expectancies of less than six months. Although Medicare coverage for noncancer patients is strictly scrutinized, third-party payers cannot bar patients based on diagnosis. Patients in the end stages of chronic debilitating diseases are often excellent candidates for the services offered. Some of the state's hospice organizations require *do not resuscitate* orders. Most accept children. All require at least telephone contact with the primary physician. Providing for patient comfort, optimal pain management and counseling and bereavement services for the patient's care providers are some of the primary elements in hospice care. Last year, almost 80% of hospice patients died in their homes. This contrasts with the 80% of overall deaths in this country that occur in hospitals.

With all the advancements that have been made in the care of the dying, it is still too commonly heard that patients were treated too aggressively or that the patient's or the family's wishes were ignored. Allowing patients to die without artificial hydration and enrolling suitable patients in hospice care are two steps physicians can take to improve their patients' final days. The Hospice Network of Maryland (5820 Southwestern Boulevard, Baltimore, Maryland 21227; 410-242-1975) is a valuable resource for physicians who need help getting a patient into a hospice program or who have questions about the care of terminal patients.

RITA ASZALOS, M.D.
Dr. Aszalos is a clinical instructor in the department of family medicine at the University of Maryland School of Medicine

JAMES P. RICHARDSON, M.D.
Editor

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Book Reviews

Gene Therapy: A Handbook for Physicians. Kenneth W. Culver, M.D. New York: NY: Mary Ann Liebert, Inc.; 1994. 117 pages. $44.95 (hardcover).

Having reached a plateau in medicine after a half century of unprecedented progress—antibiotics, anti-inflammatories, and other miraculous drugs, as well as tests and procedures that strained the imagination—along comes a brief volume that again extends the hand of almost unlimited hope. Written by Kenneth W. Culver, M.D., executive director of the Human Gene Therapy Research Institute at the Iowa Methodist Medical Center, *Gene Therapy: A Handbook for Physicians* is a relatively short treatise proclaiming the dawning of a "new era of genetic healing" that "will have potential to cure our patients instead of merely treating their symptoms."

The text is at times quite complex for a physician uninitiated in the terminology and deeper concepts of the human genome. To assist the less sophisticated reader, the author has attempted to summarize the important elements in as simple a manner as possible at the end of each chapter. At the other extreme, to avail the more knowledgeable physician of more information on the more complex issues, he has presented a voluminous list of references, also at the end of each chapter. These references are often subdivided into specific topics. In addition, an extensive list of six appendixes is provided, which includes the gene therapy studies now in progress, a glossary of terms used, an index of the hundreds of disorders believed to have chromosome abnormality components with their locations noted, and a list of the many considerations necessary prior to transferring a recombinant DNA molecule into a human subject.

Caught between the social and economic pressures of current medical practice, as well as viewing the resurrection of a number of microorganisms that have learned to survive despite our therapies, today's physicians have more often than not become somewhat depressed practicing this "noble" profession. Dr. Culver points out that trials are already in progress for the treatment of some genetic diseases, human immunodeficiency virus (HIV) infection, and a number of cancers. He states, "As this exciting new clinical discipline evolves over the next several years, gene therapy trials will become commonplace in each medical specialty."

The author refers to cancer as a "genetic disease." By realizing this, it allows us many new approaches to treatment and will eventually free us of looking for increasingly toxic chemotherapeutic agents. The author believes that in the next five to ten years, "gene therapy is likely to become standard therapy for certain forms of cancer."

Every physician, no matter what sphere of practice, will profit by reading this volume. The benefit should be twofold. First, it will provide the basis for understanding what lies ahead in this amazing field. Second, it will vindicate your earlier decision to select this distinguished profession.

MARION FRIEDMAN, M.D., F.A.A.F.P.
Baltimore, Maryland

■ ■ ■

Health Care Consumers in the 1990s. Richard K. Thomas, Ph.D. Ithaca, NY: American Demographic Books; 1993. 180 pages. $42.50 (hardcover).

In the past, the hospital was a place of refuge where needed medical care could be obtained, sometimes at financial loss to the management. The advent of a more sophisticated society having more money has evoked drastic

changes in the hospital environment. The increasingly competitive trend exhibited by modern hospitals to attract physicians—and thus, patients—has changed the practice of medicine markedly during the past decade.

In a most provocative book, Richard K. Thomas, a faculty member at Memphis State University who teaches sociology, health care administration, and marketing, provides insight and methods for furthering the commercial (and incidentally profit-making) goals of any hospital. Rightly or wrongly, Thomas presents his knowledge of the hospital environment as an informed medical strategist and socialist.

Competition between providers of health care, the shrinking market for hospital beds, major shifts in cost and risk, growing public dissatisfaction with methods of reimbursement, and alternative sources of care outside the hospital are creations of the 1980s. The doctor, caring for the patient, was once the center of the hospital world, but changing conditions, with emphasis on shorter periods of hospitalization in a congenial atmosphere and (hopefully) decreased costs, have shifted the focus toward the hospital business itself. Patients are now considered to be customers and doctors the method by which the customers may be attracted to the hospital.

Understanding consumers and promoting an attractive environment for a hospital stay are thought to be effective marketing techniques. Thomas indicates that consumers have been inundated with a flood of information about charges, procedures, qualifications, and invasive practices. They, in turn, have demanded that the system conform to their needs and not those of the physician or the hospital staff. Hospitals have become more service-oriented and therefore have shifted the focus from the period of single illness to an overall health care relationship so that institutions become more like shopping malls. A variety of services housed under one roof could offer the convenience of "one-stop shopping." Here, product, price, place, promotion, and performance could be welded into a homogenous whole. Good relationships must be created and maintained with individual customers, doctors, insurers, and hospital employees, however, before such a concept could succeed.

The aging U.S. population (12% of the population is over age 65, but represents 31% of hospital admissions) demands that therapy for degenerative conditions be given more emphasis because they are the major causes of disability, morbidity, and mortality. Indeed, analysis of existing demographic data clearly indicates that the majority of hospital beds are occupied by individuals over age 65 who have chronic illnesses. Thomas indicates that the old days of a one-time patient-doctor-hospital relationship are gone. The newer perspective envisions a period of total health care to prolong life in a hotel-like environment. How this business will be financed is not approached, but the increasing number of hospital amalgamations that provide hospital care and doctors is an event of major importance to the ordinary citizen and the practicing physician.

The book is a good review of how patients have evolved into "consumers." A number of "features" epitomizing chapter contents and "health care highlights" help explain the text. A list of suggested readings, data sources, and a good index facilitate reading. All practicing physicians would profit from a careful reading of the book, as the livelihood of many is intimately connected with future events in the rapidly expanding field of health care marketing.

JOSEPH M. MILLER, M.D.
Timonium, Maryland ■

To Our Readers

The Editorial Board of the *Maryland Medical Journal* invites you to submit reviews of books, videos, and films of interest to the medical profession. Bringing your evaluation and analysis to the attention of your colleagues will be informative and stimulating. Send your report to: Chris Papadopoulos, M.D., Book Review Editor, *Maryland Medical Journal*, 1211 Cathedral Street, Baltimore, Maryland 21201.

WORD ROUNDS

Bart Gershen, M.D.

Libation, Contemplation, and Auscultation

In 1846, Antoine-Joseph *Sax*, known to his friends as Adolphe, patented the instrument that bears his name: the **saxophone**. Those of us who have heard the syncopation, doo-wop, bebop, and jazz of people like Stan Getz, Coleman Hawkins, Buddy Tate, Sidney Bechet, John Coltrane, and Charley Parker, will be forever grateful. Mr. Sax created his musical instrument with a single vibrating reed attached to a horn with a conical bore and the standard fingering style of an oboe.

The **oboe** was once characterized by Danny Kaye as "an ill wind that no one blows good." Its name stems from the fact that it is a soprano instrument made of wood (French *haut* 'high' + *bois* 'wood'—a high wood). The word *haut* is pronounced "oh" and *bois* sounds like "bwa"; thus, "oh-bwa," which eventually became oboe. The root *haut* can be readily identified in **haughty**: insolent, conceited, or "high and mighty." It is also manifest in the borrowed French expressions ***haute couture***: "high fashion" (*couture* 'sewing') and ***haute cuisine***: "elegant food" (*cuisine* 'cooking').

In the seventeenth century, a Benedictine monk placed a cork into a fermenting bottle of wine, forcing the carbon dioxide bubbles to dissolve within the liquid. He thus created a drink that complements any haute cuisine—"sparkling wine." In France, production of this wine is exclusively confined to the old province of **Champagne**, which explains the generic name for this enchanting beverage.

The monk whose genius we toast was cellarmaster of the monastery near Eparnay, France. At age 15, he renounced the carnal world and entered the Benedictine order. Although he was blind, he possessed an uncommon sense of smell and taste that enabled him to distinguish subtleties of flavor and aroma. Several years ago, the famous winery *Moet et Chandon* named its finest champagne for this unpretentious monk. His name was Pierre Perignon—better known as **Dom Perignon.**

There are three types of champagne, depending on the sugar content. **Brut** has the lowest sugar concentration and is considered "heavy" or very "dry," that is, not sweet (French *brut* from Latin *brutus* 'dull or heavy'). Champagne with slightly higher sugar content is known as **sack** or **sec** (from the French *sec*, which stems from the Latin *siccus* 'dry'). The **sicca syndrome**, or **keratoconjunctivitis sicca**, derives from the same root. It is also called **Sjogren's syndrome** and is usually accompanied by **xerostomia** (Greek *xeros* 'dry' + *stoma* 'mouth'). The copy machine invented in 1937 by law student Chester Carlson employs a dry photo process—which is why he named it the ***Xerox***.

One need hardly state that "dry sack" is an egregious redundancy.

Champagne with the highest sugar content is called **doux**, which is French for 'sweet', deriving in turn from the Latin *dulcis*, with the same meaning. (**Dulcet** tones are sweet to the ears, and **Dulcinea**—'sweet one'—was the profligate beneficiary of *Don Quixote's* courtly affection.)

Henrik Samuel Conrad Sjogren was head of the Eye Clinic at Jonkoping, Sweden, in 1933, when he published a description of his eponymous disorder in the *Acta Ophthalmologica*. In 1935, he introduced the technique for corneal transplantation and was promoted to professor of ophthalmology at Goteburg University.

The first Benedictine monastery was founded in the year 529 at Monte Cassino, Italy, by Benedict of Nursia, known as the father of western monasticism. Members of the order wear a full black cowl and hood, from which arose the sobriquet *black monks*. One of the most renowned Benedictines was St. Augustine, who voyaged to England in 596 to convert the Anglo-Saxons to Christianity. He became the first Archbishop of Canterbury.

In 1510, at the Benedictine monastery in Fecamp, France, a monk named Don Bernardo Vincelli formulated one of the oldest and finest liqueurs ever to grace the human palate. It is called **Benedictine** and was created by those monks "to the greater glory of God." Each bottle carries the stamped initials ***D.O.M.***: *Deo Optimo Maximo* 'for the most good and great God'. The name *Benedict* itself derives from the Latin *benedictus* 'blessed', which derives in turn from *bene* 'well' + *dicere* 'to speak', that is, to speak well (of) or bless. (I'm certain the liqueur retains this invocation.)

The Benedictine monastery at Monte Cassino was located at the crest of that mountain, some 1700 feet above sea level, on the main route from Naples to Rome. During World War II, it was the scene of fierce combat as allied troops, under the command of General Mark Clark, attempted to advance from their Anzio beachhead northward into Rome. On February 15, 1944, bombers destroyed the abbey and most of the town in the famous battle of Cassino.

From the Renaissance to the present, people have hoisted their glasses of Dom Perignon, Benedictine, sherry, and other alcoholic drinks to **toast** each other, wishing success, happiness, long life, and good fortune to their friends. This ritual began in the sixteenth century and emerged from the practice of placing croutons of toast in the bottom of each glass. The toast, which was often spiced, was felt to add flavor to the drink—and perhaps adsorb acrid impurities within the alcohol (French *toster*, which stems from Latin *torrere* 'to parch or burn').

Sherry is a fortified blend of wine that originated—and continues to be produced—in the Spanish city of Jerez (full name *Jerez de la Frontera* 'of the frontier', referring to its proximity to the ancient Moorish border). The city began as a Roman colony named for Julius Caesar—*Caesariana*—which ultimately evolved to *Jerez*. The British could not easily pronounce *Jerez*, so they called its famous product **sherry**.

The word ***alcohol*** is derived from the Arabic *al koh'l*, which was originally a smooth antimony powder used by women to darken their eyelashes. Medieval alchemists applied the term to any fine, velvety powder. Soon it came to indicate the vapors of fine steam arising from a boiling liquid.

Alcoholic libations are concocted by thermal vaporization. Fermentation first creates a mixture containing alcohol, water, and other chemicals. Because the boiling point of ethanol is much lower than that of water, as the solution is heated the alcohol evaporates quickly, leaving the other ingredients behind. The vapors produced (now specifically known as *alcohol*) are then condensed as they flow through a cooling element, and the purified alcohol drips slowly into a collecting flask. The entire process is called **distillation** from the Latin *destillare*, which in turn derives from *de* 'from' + *stillare* 'to drop'. The final product is obtained—drop by drop.

Sometimes the distillery is simply called a **still**, which has often given rise to new careers such as **bootlegging**—emanating from the practice of smuggling illicit hooch within the legs of boots. (**Hooch**, incidentally, stems from the *Hoochino* Indians, a Tlingit tribe living in southern Alaska, who unfortunately learned the art of distillation from their white oppressors.)

In ancient Greece, wine was carried in large jars that had a narrow neck and two handles. Known as *amphora* (from *amphi* 'on both sides' + *pherein* 'to carry'), they were often large enough to hold 40 quarts or more, obviously requiring two bearers to carry them.

Ages ago, someone blew across the top of an empty amphora. (Coke bottles had not yet been invented.) A deep bass musical tone was produced. Many years later, a French clinician named Laennac heard such a sound arising from a tuberculous cavity. He called it **amphoric breathing.**

It sounded like a saxophone. ■

Alliance

A Special Southern Year: Mildred (Mrs. Charles E.) Taylor, SMAA President 1993-1994



Margaret Yow (l.), SMAA president 1979-1980, with Mildred Taylor (r.), SMAA president 1993-1994.

Strains of "Maryland, My Maryland" filled the air at the Southern Auxiliary Convention as the year of a Maryland president was completed in Orlando, Florida. The theme "A Circle of Flowers" came full circle in the land of flowers, where about 3000 Southerners, including many Marylanders, studied, convened, and celebrated.

A new format, a celebration of the 70th Auxiliary year and a program of working "Together for Tomorrow" filled the year. "Together" and "Unity" are natural themes for us. Our first Southern Auxiliary president from Maryland, Margaret Yow (1979-1980), stressed unity. This theme is necessary in medicine, then and now.



SMA Doctors' Day card featuring artwork by Augusto Figueroa, Jr., M.D.

"Doctors' Day—March 30," a Southern Auxiliary program, received special recognition when Maryland artwork was chosen for the new Doctors' Day card. Augusto Figueroa, Jr., M.D., and Josie Figueroa, past president of the Maryland Alliance, presented the original artwork to Mildred Taylor when she was nominated president-elect. It was subsequently used for the card, available at Southern headquarters in Birmingham, Alabama.

The new program of health education was formed with primary emphasis on breast cancer and the need for maintaining personal healthy standards. The pin bearing the words "Do the Right Thing, Get a Mammogram" was distributed to members throughout the South as Mildred and Dr. Taylor, SMA Associate Councilor (Maryland), visited the 17 states that are included in the area. New billboards and posters stressed personal responsibility: "*You* can fight breast cancer. See your physician."



Among the materials developed for the health education program was the pin stressing breast cancer awareness.

Southern is the only medical auxiliary that collects and compiles the medical heritage of its region. A new travel folder was begun that lists places of medical interest in each state. Maryland included the National Institutes of Health and the Uniformed Services University of Health Sciences, both in Bethesda (tours are available).

Medical progress relies on medical research and a Maryland tradition came to Florida. Mary Strauss, past president of AMAA and the Maryland Alliance, was our sparkling auctioneer as items from throughout the South



Auctioneer Mary Strauss at the SMAA luncheon, 70th Annual Meeting in Orlando, November 4, 1994.



Adriana Zarbin (l.) and Mildred Taylor (r.) hold the pewter platter given to Mildred by the Maryland Alliance.

were auctioned to benefit research and education, Southern style. The SMA president, Angus M. McBryde, M.D., thanked the Auxiliary and Mary for raising more than $4,000 in an hour and a half.

Georgia Lizas, with the invaluable participation of Joseph Snyder, M.D., past president of Med Chi, brought a tribute to Mildred from the Honorable William Donald Schaefer, then-governor of Maryland, and Adriana Zarbin presented a platter engraved with the best wishes of the Maryland Alliance. Georgia and Adriana are past and present presidents of the Maryland Alliance.

During the year, Mildred met with the Med Chi delegation at the AMA meeting in Chicago, attending the Maryland Family Dinner and the first Maryland Alliance reception held at the Drake Hotel. At that meeting, a plaque of appreciation was presented to the AMAA board of directors for their participation in the Doctors' Day postal plate project, an enterprise begun by Mildred in Maryland. Later, another plaque of recognition was given to the American Cancer Society at its board of directors meeting in Atlanta, Georgia, with 400 members in attendance.

The Southern Auxiliary membership exceeds 25,000, of which 2000 are husbands of women physicians. Dr. Reynaldo Lee-Llacer served on the 1993-1994 board as the first male member, working with Ching (Mrs. Albert) Barretto on international liaison. We appreciate his interest and participation.

Memories of Southern will run deep, from the beautiful reception given for Dr. and Mrs. Taylor and the incoming president to the crab mallets given to SMA Council. They are to be used when Southern meets in Baltimore in November 1996. For now, we remember the year when all Southern Marylanders worked together for medicine and health, with plans to meet in Kansas City in November 1995.

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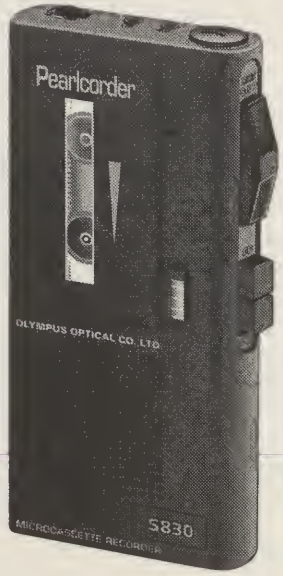
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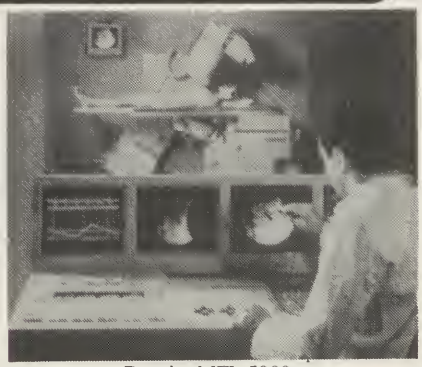
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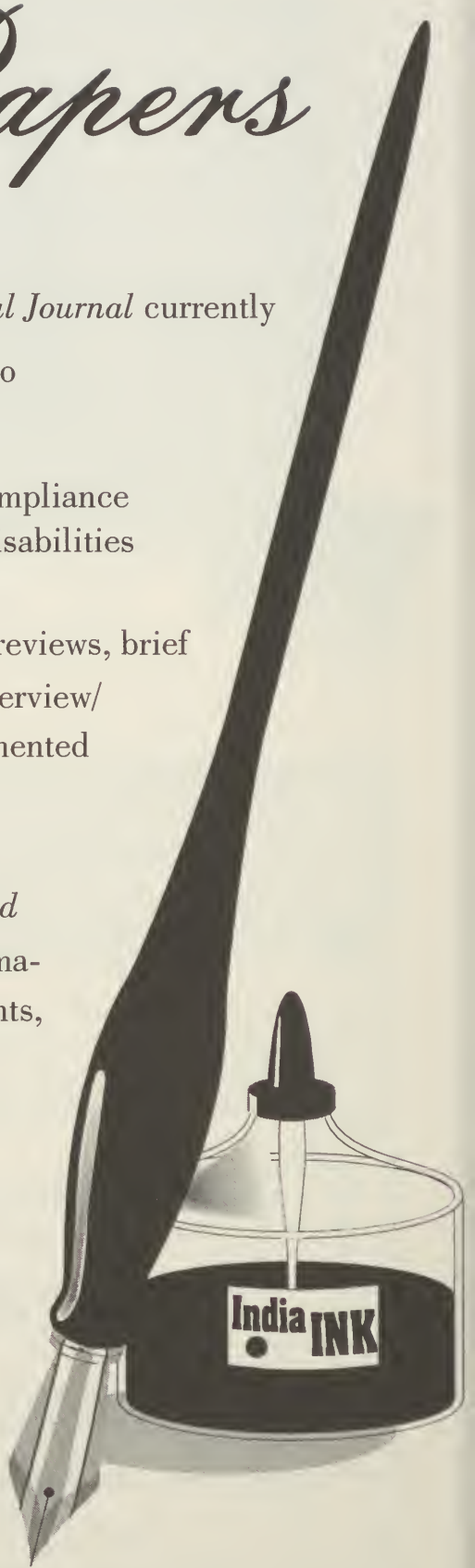
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WE NEED A DOCTOR IN THE HOUSE

DOCTOR OF THE DAY 1995

Note: All Monday dates are evening sessions, beginning at 5:00 pm and ending at 9:00 pm. For more information, call Joyce Yensen at Med Chi's Legal Department, 410-539-0872 or 1-800-492-1056, toll free in Maryland.

When the Maryland General Assembly convenes in Annapolis for its 1995 session, the Medical and Chirurgical Faculty will be there. Since 1964, Med Chi has staffed the first aid facility operated during the 90-day legislative session. Come join us at the state capitol building and see law being made firsthand. One doctor a day is all that is needed to care for the public, the legislators, and their staffs. Take advantage of the opportunity to donate something priceless -- your time.

Please detach, fill in and mail the postcard located above. You will be sent a confirmation card explaining details. Your participation means the continuation of a tradition established by the medical community for the people of Maryland.

YOUR TIME CAN MAKE A DIFFERENCE.

The Maryland Medical Journal (MMJ) *is a monthly publication of the Medical and Chirurgical Faculty of Maryland. The journal's goals are educational and informative: the publishing of scientific articles (original research, case studies, and review articles) and other technical information, as well as editorials, letters, special articles (evaluations, position papers, reviews of nonscientific subjects), membership and legislative news, continuing medical education notices, and programs and policies of the faculty.*

Information for AUTHORS

- ***Letter of transmittal***—The letter of transmittal, which all authors must sign, should include the full names, degrees, titles, and affiliations of all authors, and the name, address, and phone number of the author to whom reprint requests and correspondence should be sent.

  The letter should include a statement to the effect that all authors have participated in the conception and design of the work and in the writing of the manuscript, and that they take public responsibility for it. The authors should attest to the validity and legitimacy of the data, and acknowledge that they have reviewed the final version of the manuscript and approve it for publication.

  In addition, the letter must include a paragraph that transfers copyright ownership to the *MMJ* in the event that the work is published.

- ***Manuscript preparation***—Manuscripts should be submitted to Editor, *MMJ*, 1211 Cathedral Street, Baltimore, MD 21201-5585. Manuscripts must be original material not previously published and not under consideration by another publication. An abstract of 100 to 300 words is required.

  All material, including references, tables, and legends, must be double-spaced. Pages should be numbered. (All abbreviations should be spelled out on first use.) The original manuscript plus one copy should be submitted on standard (8.5" x 11") bond paper. If at all possible, an IBM-compatible disk should be included, with the manuscript entered in a WordPerfect, Multimate, Wordstar, or ASCII format; the transmittal letter should identify the format used.

- ***References***—References are limited to those citations noted in the text. References should be numbered consecutively as they appear in the text and should be kept to a minimum (fewer than thirty-five). Personal communications and unpublished data are not acceptable. At a minimum, references should include names of all authors, complete title of the article cited, name of journal abbreviated according to *Index Medicus* (if abbreviation is not known, journal name should be spelled out fully), year of publication, volume number, and first and last page numbers. Sample references are as follows:

  1. Stevens MB. The clinical spectrum of SLE. Md Med J 1991; 10:875–85.
  2. Ropes MW. Characteristics, manifestations, and pathologic findings. In: Ropes MD, ed. Systemic Lupus Erythematosus. Cambridge, MA: Harvard University Press. 1976; 50–4.

- ***Tables***—Tables should be typed on separate sheets of paper, be numbered, and have a brief descriptive title. Data presented in tables should be self-explanatory and should supplement, not duplicate, the text; the Editor reserves the right to edit tables. Authors should be sure that statistics are consistent in both tables and text.

- ***Illustrations***—Illustrations include material that cannot be set in type. Photographic material must be submitted as high-contrast, glossy prints. Drawings and graphs must be done professionally in india ink on high-grade white drawing paper or be computer generated. Identification—including figure number, the title of manuscript, the name of corresponding author, and arrow indicating top—should be typed on a gummed label and affixed to the back of each illustration. Legends for illustrations should be typed on a separate page with numbers corresponding to those on the photographs or drawings. Recognizable photographs of patients are to be masked and should carry with them written permission for publication. Cost of printing color photographs must be borne by the author.

- ***Permissions***—Material taken from other sources must be accompanied by written permission from both author(s) and publisher allowing the *MMJ* to reproduce the information/figure.

- ***Editorial responsibility***—All manuscripts are acknowledged upon receipt. They are subject to peer review by an editorial board and, at times, by guest reviewers in appropriate fields of medicine, to determine the originality, validity, and importance of the content and conclusions. Authors are usually notified of the status of their papers (acceptance, revision, or rejection) within 4 to 8 weeks of receipt; however, longer delays are sometimes unavoidable. Reviewers' comments will be returned with rejected manuscripts at the discretion of the Editor. All guest reviewers will remain anonymous.

  Accepted manuscripts become the permanent property of the *MMJ* and are subject to copy editing. (The *Chicago Manual of Style* and the unabridged *Random House Dictionary of the English Language* are used as style guides.) The corresponding author is sent a reprint order form and galley proofs. S(he) then has 48 hours in which to make minor changes and clear all corrections and changes with co-authors; if proofs are not returned by the specified date, they will be considered approved as typeset. ■

Checklist

- ☐ Original manuscript and one copy.
- ☐ IBM-compatable disk in WordPerfect, Multimate, Wordstar, or ASCII.
- ☐ Everything double-spaced.
- ☐ Letter of transmittal, signed by all authors, that includes release of copyright, statement of authorship responsibility, title and affiliation of all authors, and identification and phone number of corresponding author.
- ☐ Abstract of 100 to 300 words.
- ☐ Permission-to-borrow letters for any previously published illustrations or tables

University of Maryland

For each course, additional information may be obtained by contacting the Program of Continuing Education, University of Maryland School of Medicine, Room 14-011, BRB, 655 W. Baltimore St., Baltimore, MD 21201 (410-706-3956) or by calling the phone number listed after a specific program. FAX 410-328-3103.

Physician forum HIV: HIV care provision—medical, legal, and ethical dilemmas, at the Brass Elephant Restaurant, Baltimore, MD. 1 Cat 1 AMA credit. Info: Sylvia Scherr, 410-328-5759. — **March 16**

Noninvasive vascular testing—the whole story, at Harbor Court Hotel, Baltimore, MD. 15 Cat 1 AMA credits. Fee: $325/physicians; $250/techs. Info: Judith Brannan 1-800-982-2011. — **April 21–22**

Maryland Otolaryngology, Head & Neck Surgical Society: resident research presentations, at the Greater Baltimore Medical Center, Towson, MD. 3 Cat 1 AMA credits. $165. Info: J.F. Biedlingmaier, M.D., 410-225-8072. — **April 25**

8th Annual trauma anesthesia & critical care symposium, at the Hyatt Regency Hotel, Baltimore, MD. Cat 1 AMA credits. Info: Kimberly Unitas, 410-328-2399. — **May 11–13**

Physician forum HIV: beyond the recommendations—how we really care for AIDS patients, at the Brass Elephant Restaurant, Baltimore, MD. 1 Cat 1 AMA credit. Info: Sylvia Scherr, 410-328-8639. — **May 18**

21st Annual family medicine review course, at the Princess Royale Ocean Suite Hotel, Ocean City, MD. Cat 1 AMA/AAFP credits. Info: Althea Pusateri, 410-706-3956. — **June 25–30**

Managing emergency medical services, at the University of Maryland Baltimore County (UMBC). Sponsored by the UMBC Department of Emergency Health Services and the Maryland Institute for Emergency Medical Services Systems. Info: Dr. Richard Bissell, 410-455-3776. — **July 2–28**

Miscellaneous meetings

1995 Risk management program: suit survival/lessons in risk management, sponsored by Medical Mutual Liability Insurance Society of MD. Med Mutual members who attend will receive a 5% discount on 1996 renewal premium. 2 Cat 1 AMA credits. Fee: $40.00. Info: Toni Davis or Natalie Poole, 410-785-0050, or 1-800-492-0193.

Medical Mutual	**March 7**
Peninsula Reg. Med. Ctr.	**March 8**
Calvert Memorial	**March 9**
Med Chi	**March 22**
Comfort Inn, Easton, MD	**March 23**
Shady Grove Advent. Hosp.	**March 28**
P.G. Hospital Ctr.	**March 29**

Miscellaneous meetings (continued)

Minimally Invasive Training Institute (MISTI), sponsored by Saint Joseph's Medical Center. Info: Sharon Sopp, 410-337-1536.

Laparoscopic hernia repair, 4 Cat 1 AMA credits. **March 7**

Laparoscopic or thoracoscopic spinal surgery, 7 Cat 1 AMA credits. **March 15**

Laparoscopic colon resection, 6 Cat 1 AMA credits. **March 21**

Lap-assisted vaginal hysterectomy & laparoscopic supracervical hysterectomy, 8 Cat 1 AMA credits. **March 28**

Fifth annual dance medicine symposium, sponsored by Union Memorial Hospital, HealthSouth Spine and Physical Therapy Center and Goucher College, at the Todd Dance Studio of Goucher College. Info: Andrea DiStefano, P.T., 410-296-0511. **March 11**

Fifth annual AAMI/FDA international standards conference on medical devices, "International standards and regulatory harmonization," at the Crystal Gateway Marriott Hotel, Washington, DC. Info: 800-332-2264 or 703-525-4890, ext. 260. **March 16–17**

March 24–25

Fourth annual spring clinical nephrology meetings primary care nephrology program, sponsored by the National Kidney Foundation at the Sheraton Washington Hotel, Washington, DC. Info: 1-800-622-9010. **Feb. 24–25**

Twelfth annual symposium on practical neurology for the primary care physician, sponsored by the Education Committee and the division of neurology of Saint Joseph Medical Center at Saint Joseph Medical Center. Fee: $35/physicians; $20/nurses, allied health professionals. 7.5 Cat 1 AMA/AAFP credits. Info: 337-1501. **March 25**

Clinical perspectives on violence conference, at Sheppard Pratt Conference Center, Baltimore, MD. 6 Cat 1 AMA/PRA credits. Fee: TBA. Info: Professional Education Programs, 410-938-4598. **March 25**

Substance abuse '95: programs in policy and practice, at the George Washington University Medical Center. 5.5 Cat 1 AMA credits. Info: Martha Cosgrove, 202-994-4536. **March 25**

Reflux and ulcer disease advanced laparoscopy course, at the George Washington University Medical Center. Info: Maria Gorrick, 202-994-4285. **March 31**

Comprehensive HIV management update for the primary care physician, at the Palace Hotel in New York City. 21 cat 1 AMA/AAFP/AAPA credits. Info: Svetlana Lisanti, 201-385-8080. **March 31–April 2**

Third world congress on stress, trauma and coping in the emergency services professions, at the Sheraton Inner Harbor Hotel, Baltimore, MD. Info: 410-730-4311. **April 19–23**

Mental health services for older adults: building a regional continuum of care conference, at the Sheppard Pratt Conference Center, Baltimore, MD. 5.75 Cat 1 AMA/PRA credits. Fee: TBA. Info: 410-938-4598. **April 22**

Clinical innovations in OB/GYN ultrasound, sponsored by Meetings & Management Techniques Plus and The American Institute of Ultrasound in Medicine, at the Lowes L'Enfant Plaza, Washington, DC. 14.5 Cat 1 AMA/PRA credits and 15 Formal Learning Cognates by ACOB/GYN. Info: Ann Boehme, 516-561-4223. **April 22–23**

Miscellaneous meetings (continued)

Caring for the diabetic lower extremity: a practical approach for primary health care providers, sponsored by the American Diabetes Assoc., MD Affiliate and the MD Podiatric Medical Assoc., at the Sheraton International Hotel, BWI Airport. 7 Cat 1 AMA credits and 7 credit hours by the Maryland Board of Podiatric Examiners. $125/ physicians; $100/ACP members; $75/other health professionals. Info: 410-526-2900. **April 28**

Third international symposium on maritime health, sponsored by the George Washington University Medical Center, at the Maritime Institute of Technology and Graduate Studies, Baltimore, MD. 14 Cat 1 AMA credits. $1350 (includes lodging and some meals). Info: Karen Mayer, 202-994-3921. **June 7–9**

2nd Annual intensive review of internal medicine, sponsored by the George Washington University Medical Center, at the Washington Marriott Hotel, Washington, DC. Info: Deborah Grant, 202-994-4285. **June 7–10**

3rd Annual board review in family medicine, sponsored by the George Washington University Medical Center, at the Marriott Crystal Gateway Hotel, Arlington, VA. 39 cat 1 AMA/ AAFP credits. Info: Maria Gorrick, 202-994-4285. **June 24–28**

6th Biannual gastroenterology board review course, sponsored by the George Washington University Medical Center, at the Grand Hyatt, Washington, DC. Fee and Credits TBA. **Oct. 7–11**

Medical oncology board review course, sponsored by the George Washington University Medical Center, at the Ritz-Carlton Pentagon City, Arlington, VA. Fee and Credits TBA. **Oct. 8–12**

Continuously throughout the year

Fluorescein angiography conference, sponsored by the Retina Center, Saint Joseph Hospital, Baltimore, MD, first and third Mondays of each month; 8:00–9:00 am. Fee: none. Info: R. Classon, 410-337-4500.

PHYSICIAN'S RECOGNITION AWARD

During December 1994, the physicians listed below received the American Medical Association Physician's Recognition Award. Established in 1968, the award's purpose is to encourage physician participation in continuing medical education and to recognize those physicians who have voluntarily completed programs of continuing medical education.

Gershon H. Bergeisen, M.D.
William Hakkarinen, M.D.
Elisabeth Lejman, M.D.
Sandra M. Miller, M.D.
Luis E. Renjel, M.D.
Donald E. Wilson, M.D.

The Johns Hopkins Medical Institutions

All courses at the Thomas B. Turner Building unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Medical Education, 720 Rutland Ave., Baltimore, MD 21205 (410-955-2959).

Nuclear oncology, 16 Cat 1 AMA credits. $495/physicians; $395/residents, fellows, and allied health professionals.	**March 8–10**
Principles and practice of clinical MRI, at the Renaissance Hotel, Washington, DC. 21.5 Cat 1 AMA credits.	**March 23–26**
Fifth annual perspectives on clinical nutrition, 11 Cat 1 AMA credits.	**March 24–25**
Spectrum of developmental disabilities XVII, 20 Cat 1 AMA credits.	**March 27–29**
Diagnosis and treatment of neoplastic disorders, 13.5 Cat 1 AMA credits. $325/physicians; $150/residents, fellows, and allied health professionals.	**March 30-31**
36th Annual postgraduate institute for pathologists in clinical cytopathology, 136 Cat 1 AMA credits.	
Course A (Home Study)	**Feb-March**
Course B (Johns Hopkins Medical Institutions)	**April 3–14**
The care of patients with Alzheimer's and other dementias, at the Stouffer Harborplace Hotel, Baltimore, MD. 5.5 Cat 1 AMA credits available. $120/physicians; $75/residents, fellows, and allied health professionals.	**April 1**
23rd Annual pediatric trends, 42 Cat 1 AMA/AAP credits. $650/physicians; $450/residents and fellows.	**April 3–8**
Clinical care of the patient with HIV infection, at the Stouffer Harborplace Hotel, Baltimore, MD. 12.5 Cat 1 AMA credits. $325/physicians, $175/residents, fellows, and allied health professionals.	**April 6–7**
Current concepts in thyroid disease: update 1995, 8.5 Cat 1 AMA credits. $160/physicians; $30/residents and fellows.	**April 21**
Ninth annual mood disorders symposium, Cat 1 AMA credits pending. $50/DRADA members; $60/other.	**April 25**
Wilmer nursing conference	**April 28**
Pediatric allergy and immunology for the practitioner, 14 cat 1 AMA credits. $255/ physicians; $175/residents and allied health professionals.	**May 4–5**
Contemporary issues in the diagnosis and treatment of low back pain	**May 4–6**
In vitro toxicology	**May 8–10**
Rheumatology nursing	**May 12–13**
40th Annual topics in clinical medicine, 39.5 Cat 1 AMA credits, 37 prescribed credits by AAFP. Fee: $750/physicians; $600/residents, fellows, others.	**May 15–19**
Advanced pediatric life support, 20 cat 1 AMA credits.	**June 12–14**
Design and analysis in clinical trials, 15 cat 1 AMA credits.	**June 15–16**

The Johns Hopkins Medical Institutions (continued)

Continuously throughout the year

Visiting preceptorship in pediatric critical care medicine. Ongoing five-day preceptorship by appointment. 40 Cat 1 AMA/PRA credits. $600.

The department of radiology and radiological sciences offers several courses in abdominal and obstetrical ultrasound. Info: P. Williams, 410-955-3169.

Visiting physicians. Offered throughout the year for experience in the lab and participation in read-in sessions; by appointment only. 40 Cat 1 AMA/PRA credits. $500.

Johns Hopkins medical grand rounds. Accredited audiovisual continuing education series of case discussions for clinicians; 30 topics per year in five bimonthly programs. Individual and group subscriptions. 40 Cat 1 AMA/PRA credits. Info: 410-955-3988.

Johns Hopkins sports medicine grand rounds. Accredited continuing education series of case discussions by a different presenter on the first Thursday of each month. Info: Carol Kelly, 410-383-0600.

PERFORMING ARTS MEDICINE III: March 31 - April 1, 1995

Med Chi Faculty Building
1211 Cathedral St., Baltimore, MD 21201

The third conference on performing arts medicine continues Med Chi's tradition of advancing the knowledge of health care professionals, performers, and educators regarding health problems faced by musicians, vocalists, and dancers.

For further information, please contact Susan Harman, Med Chi's Music Medicine Clearinghouse Coordinator, at 410-539-0872 or 1-800-492-1056 (in Maryland).

PAIN AND THE PERFORMER

This year's program emphasizes the diagnosis, treatment, and prevention of painful disorders and consists of eight presentations, a recital/lecture, and three master classes.

Topics to be discussed include:

- hand surgery outcomes
- noise-induced hearing loss
- breathing difficulties
- vocal malfunction
- health screening for dancers
- personal health programs for optimal performance
- primary care for performers

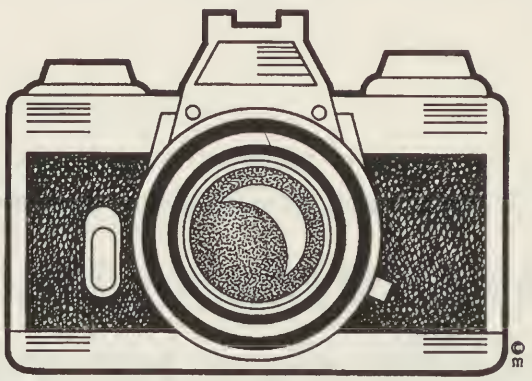
The program also has two special features:

- *Internet*—a presentation on music medicine resources available through the Internet will include small group demonstrations, where participants can view actual searches of databases and listservs discussed.
- *Master Class/Clinics*—physicians will have the opportunity to observe a master class taught by a vocal or instrumental teacher. A health professional will expand the lesson into a clinical demonstration, relating health outcomes to artists' practices and performances.

Enter the Fifteenth Annual Med Chi PHOTO CONTEST!

Contest is open to all Med Chi and Alliance members.

Two categories: black & white OR color with first and second prizes awarded in each category.



Deadline for entries is Friday, March 17, 1995.

All entries will be displayed at the 1995 annual meeting at the Inn and Conference Center, College Park.

Photo Contest Rules:

Eligibility: All members of Med Chi and members of the Alliance may enter. Professional photographers may not enter.

1. Photographs may be submitted in two categories: black and white OR color.
2. Limit: three entries per person.
3. Prints only; prints smaller than 8" x 10" or larger than 11" x 14" will not be accepted. If your favorite shot is a slide, you must have a print made within this size range to enter the contest.
4. Entries must be matted or dry mounted. No framed photographs will be accepted.
5. Entries must have name, address, and telephone number attached to the back of each photograph.
6. Entries may be mailed or brought to Med Chi, 1211 Cathedral Street, Baltimore, MD 21201 by 5:00 pm on March 17.
7. Photographs entered in the contest will be on display at the 1995 annual meeting.
8. Prizes will be awarded to the first and second place winners in each category.
9. Winners will be announced at the annual meeting of the Medical and Chirurgical Faculty, May 4-6, 1995.
10. Photographs will not be mailed back. They may be claimed at the registration desk at the close of the annual meeting at noon on May 6 or at Med Chi thereafter.
11. Med Chi does not guarantee against loss or damage of any kind to the photographs submitted to the contest.

Parris N. Glendening — Governor of Maryland

DHMH Maryland Department of Health & Mental Hygiene

Martin P. Wasserman, M.D., J.D. — Secretary
Department of Health & Mental Hygiene

J. Mehsen Joseph, Ph.D. — Director
Community Health Surveillance & Laboratories Admin.

Ebenezer Israel, M.D., M.P.H. — Director
Epidemiology & Disease Control Program

EPIDEMIOLOGY & DISEASE CONTROL PROGRAM
201 W. Preston Street, Baltimore, Maryland 21201 (410)225-6700

March, 1995
Malaria: Are Your Patients Who Travel Protected?

A 24 year old woman comes to your office. In one month she will be going on a two month trip to Mexico City to work as a photographer's assistant. Later that day, a 45 year old man calls your office saying he is going to be travelling in Asia for six weeks. Among other travel advice they are seeking, they both want to know if they need to take medicines for malaria.

Travelers' questions about malaria prophylaxis are not uncommon as more people travel to malaria-endemic countries, and more people who are foreign-born return to visit their countries of origin. **Malaria case reports increased in Maryland in 1994. Assuring adequate prophylaxis for your patients is the key to prevention.** The following article reviews information about malaria, the recent epidemiology of cases in Maryland, and recommendations for prevention.

Malaria: The Disease

Malaria is caused by a bloodborne parasite and is acquired by humans from the bite of an infected anopheline mosquito. Mosquitos become infected when they contract malarial gametocytes during a blood meal from an infected person. Although the mosquitos in the United States and Canada are no longer infected with the malaria parasite and are unable to transmit the parasite, malaria remains endemic in many other areas of the world including Central and South America, sub-Saharan Africa, the Indian subcontinent, Southeast Asia, the Middle East and Oceania. During the eighteenth and nineteenth centuries, malaria was endemic to the United States and Canada and the Federal Centers for Disease Control and Prevention (CDC) was originally founded as the Office of Malaria Control.

There are four species of plasmodia that infect human beings: *Plasmodium falciparum, P. vivax, P. ovale* and *P. malariae*. The incubation period ranges between one to two weeks. A typical malaria paroxysm begins with a violet rigor that can last from a few minutes to an hour. Fever ensues that can reach 104 to 106 degrees Fahrenheit lasting three to eight hours followed by defervescence, diaphoresis and lethargy. The periodicity of fevers in malaria relates to the synchronization of the erythrocytic cycles, with rupture of the red blood cell and liberation of the parasites. *P. falciparum, P. vivax* and *P. ovale* classically produce fevers every 48 hours and *P. malariae* every 72 hours. *Plasmodium falciparum* is

found primarily in tropical regions and poses the greatest risk of death for non-immune travelers. *P. falciparum* is able to infect red cells of all ages, resulting in high levels of parasitemia and fulminant illness. Complications of infection can include anemia with red cell destruction, cerebral malaria, renal failure, and pulmonary edema. "Blackwater fever" refers to the discoloration of the urine from high amounts of hemoglobin and malarial pigments. Malarial complications are due to microvascular disease caused by adherence of parasitized red cells to capillary walls or through cytokine mediated effects (e.g., by TNF-alpha).

P. vivax and *P. ovale* are endemic in more temperate areas. These two species infect only younger red blood cells and generally cause less serious infection. Due to a dormant liver stage, relapses can occur 6 to 11 months after the initial infection. *P. malariae* can persist in the bloodstream at low levels for up to 30 years. There is no permanent immunity to any of the *Plasmodium* species; natives of a malaria-endemic country may develop some amount of immunity, but can still become infected and experience symptoms.

Epidemiology of Maryland Malaria Cases

During 1994, reported cases of malaria in Maryland increased. As of November 1994, 78 cases of malaria were reported among Maryland residents compared to 57 cases for all of 1993. The average number of cases per year from 1989 to 1992 was 56 (range = 42 to 62). Twenty-five percent of those ill were under the age of 20, and 42 percent were women.

Among the 78 cases in 1994, *P. falciparum* was recovered in 59 percent , *P. vivax* and *P. ovale* in 35 percent and *P. malariae* in 3 percent; 27 cases were reported without the species being specified. There were no cases of co-infection by more than one species noted in 1994. CDC Surveillance forms were completed by physicians or local health department personnel, and mailed to Maryland Department of Health and Mental Hygiene on only 42 of the 78 cases. All of the cases were imported from other countries. *P. falciparum* was acquired mainly by travelers to Africa, and by one to India. *P. vivax* was acquired primarily in India and Central America, with one case in Africa.

Sixty-six percent of the cases reported that they had not taken any malaria prophylaxis. Among the 33 percent who were given medication for prevention, it is not known whether it was the appropriate medication or whether it was taken in adequate doses.

Reasons for malaria's increase in Maryland in 1994 are not clear but likely include more adventurous travel and greater numbers of immigrants in the area who may be more likely to travel to malaria-endemic areas. Reported cases for the nation as a whole have remained approximately 1,000 per year for the last few years. The vast majority of cases are acquired out of the country by travelers and recent immigrants. A handful of cases (less than 10 in the last decade) have been reported that are thought to have been acquired in the U.S.

Travel Recommendations

Malaria is a largely preventable illness for the traveler. Prevention lies in reducing the likelihood of mosquito bites and taking chemoprophylaxis if indicated. The two travelers mentioned in the examples above should be applauded for planning in advance and for seeking medical advice weeks before

their departure dates.

In prescribing preventive medicines for your patients you will need to consider their risk of exposure which will include **the country they are visiting**, and **whether they will be staying in rural or urban areas**. By and large, the urban centers of most affected countries are extremely low risk. The rural areas are high risk. For specific detailed information, the CDC's Health Information for International Travel, or the CDC travel hotline (see below) should be consulted. Drug resistance, particularly chloroquine resistance in *P. falciparum* must also be considered in prescribing the appropriate medication.

In the case of the first traveler, her trip to Mexico City is low risk. If she is to be staying in the city, medication would not be indicated. She should be questioned about whether she plans trips to the countryside, particularly during the hours of dusk to dawn when mosquitos are more likely to bite. If she is going to rural areas, then chemoprophylaxis is appropriate. Central America is still chloroquine-sensitive and **chloroquine** would be used at 500 mg taken orally each week (for adults) (see table below), beginning one to two weeks prior to travel and continuing four weeks after returning. Common side effects of chloroquine are gastrointestinal disturbances, headache, dizziness and pruritus. Starting medicines in advance allows for better prophylaxis, as well as making sure the patient will tolerate the medicine before leaving home.

The traveler to Asia will need to be questioned about his itinerary. Visiting cities is of low risk, except for Delhi and Bombay, India which are both considered high risk. A tour of rural areas would, of course, be high risk and preventive medicine indicated. Asia has chloroquine-resistant malaria and **mefloquine** (see table below) is the correct medication. Resistance to mefloquine has been reported in Thailand and doxycycline is used for travelers to that country. **Mefloquine** (marketed as Larium®) is dosed at 250 mg (for adults), taken orally once a week starting one to two weeks before departure, and taken through four weeks after returning. Common side effects are similar to chloroquine. In higher doses mefloquine has been associated with psychoses and convulsions and is not recommended for people with a history of epilepsy or psychiatric disorders. It is also not recommended for pregnant women under current F.D.A. licensure.

TABLE Drugs Used in The Prophylaxis of Malaria

Drug	Adult Dose	Pediatric Dose
Mefloquine (Lariam®)	228 mg base (250 mg salt) orally, once/week	15-19 kg: 1/4 tab/wk 20-30 kg: 1/2 tab/wk 31-45 kg: 3/4 tab/wk >45 kg: 1 tab/wk
Doxycycline	100 mg orally, once/day	>8 years of age: 2 mg/kg of body weight orally/day up to adult dose of 100 mg/day
Chloroquine phosphate (Aralen®)	300 mg base (500 mg salt) orally, once/week	5 mg/kg base (8.3 mg/kg salt) orally, once/week, up to maximum adult dose of 300 mg base
Hydroxychloroquine sulfate (Plaquenil®)	310 mg base (400 mg salt) orally, once/week	5 mg/kg base (6.5 mg/kg salt) orally, once/week, up to maximum adult dose
Proguanil	200 mg orally, once/day in combination with weekly chloroquine	<2 years: 50mg/day 2-6 years: 100 mg/day 7-10 years: 150 mg/day >10 years: 200 mg/day
Primaquine	15 mg base (26.3 mg salt) orally, once/day for 14 days	0.3 mg/kg base (0.5 mg/kg salt) orally, once/day for 14 days

Source: Health Information for International Travel, 1994
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

After returning from all countries except Haiti, for the final two weeks of medication, primaquine may be added. Primaquine acts against the liver stages of *P. vivax* and *P. ovale* and can help prevent

relapses with these organisms. It is dosed at 26.3 mg taken orally, once a day for 14 days, but is generally only recommended for persons who have had prolonged exposure in malaria-endemic areas, e.g., missionaries and Peace Corps Volunteers. Despite prophylaxis, relapses are possible for up to four years after exposure.

Both patients should be instructed regarding general measures to avoid mosquito bites. Long sleeves and long pants should be worn if possible, particularly from evening to morning. Insect repellent containing N,N diethylmethyltoluamide (DEET) should be used on exposed body surfaces. Products containing concentrations of 30 to 35 percent DEET should be adequate, and its effect lasts about four hours. If the traveler will not be sleeping in an enclosed, well screened area, mosquito netting should be used. Bednets are more effective if treated with permethrin or deltamethrin. As a reminder, there will be times of the year in more temperate climates when it will be cold enough that mosquitos will not be out. During these times of year in particular countries, chemoprophylaxis would be unnecessary.

Educating your patients before they travel is important. The data in Maryland for 1994 show that prophylaxis was not taken at all in most cases. Try to identify patients in your practice who are likely to travel to malaria-endemic areas and remind them to contact you before they travel. A population of particular concern is foreign-born patients who plan to travel but who may not understand their risks or think that they are immune. Additionally, they may be more likely to travel to rural areas where malaria risk is greater. It is not safe for them to assume that because they have lived in another country that they cannot contract malaria in that country when they return.

Specific prophylactic regimens and treatment advice from the CDC is available via the automated travelers' hotline at (404) 332-4559. The CDC Health Information for International Travel 1994 which can be ordered from the U.S. Superintendent of Documents in Washington, D.C. at (202) 783-3238 is another useful resource for doctors and travelers. Travel clinics are available in Maryland and Washington, D.C. and specialize in making comprehensive recommendations regarding appropriate immunizations and prophylactic medications.

Prevention of infection is important at the individual and community level. For the individual, illness and its attendant complications can be avoided. Preventive medication and prompt treatment of cases safeguards the health of the community by lowering the chance of introducing malaria into the mosquito population and subsequently further spreading it through our communities.



Submitted by Charlotte Kratt, M.D.
University of Maryland,
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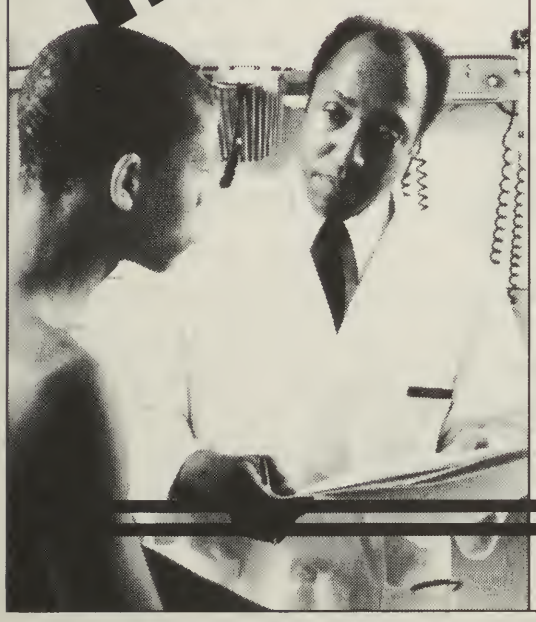
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Helicobacter pylori has attracted widespread attention because it is thought to be a common cause of peptic ulcer disease and other common gastrointestinal symptoms. There also appears to be an etiological link between *H. pylori* and gastric cancer. Details regarding *H. pylori* transmission, however, are scarce. Kelly et al (*Gastroenterology* 1994;107:1671-1674) cultured *H. pylori* from the stools of 12 of 25 patients with ulcer symptoms and positive stomach cultures. Sensitive molecular biology studies confirmed that the bacterium found in the stomach was the same as the organism isolated from the feces, suggesting that *H. pylori* is transmitted via an oral-fecal route similar to many other GI infections such as bacterial diarrhea and infectious hepatitis. In another provocative observation reported by Weber et al (*Gastroenterology* 1994;107:1835-1838), a patient with a large gastric lymphoma was found to have a concomitant *H. pylori* infection. After treatment of the infection with antibiotics, marked regression of the lymphoma occurred. **_H. pylori_ infection of the stomach should be included in the differential diagnosis for many upper GI complaints and further investigation is warranted if prompt and lasting clinical response is not achieved with symptomatic therapy.**

Bile acid sequestriants are safe and effective for reducing plasma levels of low-density lipoprotein cholesterol, but gastrointestinal side effects may be severe and treatment limiting. In a double-blind, placebo-controlled, crossover study (*Arch Fam Med* 1994;3:955-960), the bulk-forming laxative psyllium hydrophilic mucilloid (PHM) was added to cholestyramine therapy in patients with a primary diagnosis of hypercholesterolemia. PHM significantly reduced the frequency and severity of cholestyramine-induced constipation, abdominal discomfort, and heartburn. Believing the study to be the first to document such benefits, the authors conclude that **PHM supplementation may be an inexpensive, safe, and effective way to reduce the GI side effects of cholestyramine.**

Data from the National Highway Traffic Safety Administration (NHTSA) indicate that **from 1982 to 1993, the number of alcohol-related traffic fatalities decreased 31%,** from 25,165 to 17,461. In 1993, South Carolina had the lowest percentage of alcohol-related traffic fatalities (27.9%), Maryland had the second lowest (28.2%), and Texas had the highest (58.9%). In 1990, alcohol-related crashes cost $46.1 billion, including $5.1 billion in medical expenses. NHTSA's goals of further reducing alcohol-related traffic fatalities and increasing seat belt use could save 2900 lives and $5.8 billion per year, including $1 billion in health care costs (*MMWR Morb Mortal Wkly Rep* 1994;43(7):861-864).

The safety of the sympathomimetic decongestant pseudoephedrine, frequently used in over-the-counter preparations, has been questioned in patients with hypertension. Results of a randomized, placebo-controlled, double-blind crossover trial indicate that at standard doses, **pseudoephedrine has no significant effect on systolic or diastolic blood pressure in patients with controlled hypertension** (*J Fam Pract* 1995;40:22-26).

Cite SEER

In a nationwide household telephone survey of **adult medical care consumers** (*Arch Fam Med* 1994;3:948-953), respondents **were asked to rate physicians in seven areas of competency:** diagnosing and treating illnesses, communication, ethical conduct, cooperation with other health professionals, promotion of preventive care, use of technology, and consideration of the cost of care to the patient. Results were compared with a survey of 300 randomly selected physicians who were asked how important they believe it is for medical education to provide training in 17 competency areas. **The lowest ratings** from both groups **were in the areas of communication skills and attention to the costs of recommended treatment.**

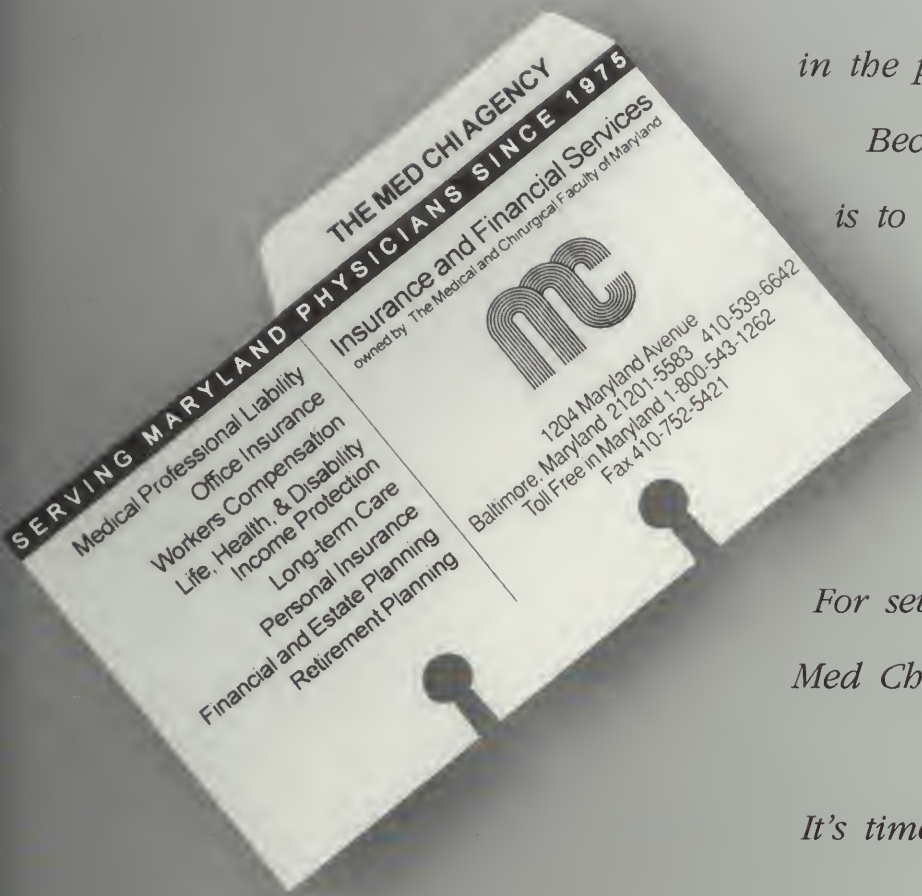
Defendant physicians involved in malpractice litigation are often told not to speak to anyone about any aspect of the case. As the Committee on Professional Liability of the American College of Obstetricians and Gynecologists points out, however, literal adherence to such advice can result in isolation, increased stress, and dysfunctional behavior (ACOG Committee Opinion, Number 150, Dec. 1994). Recognizing that **professional counseling may help physicians deal with the intense stress of defending a malpractice suit,** ACOG recommends that if the clinical aspects of the case are to be discussed in counseling, **the context should be a formal counselor-patient relationship to ensure the confidentiality privilege.**

In a study of elderly patients with hip fractures, higher short- and long-term mortality was associated with being male, being older, living in a nursing home prior to fracture, having a higher comorbidity score, and having a pertochanteric fracture (*Am J Public Health* 1994;84:1287-1291).

An observational follow-up study of 126 women and 607 men with acute myocardial infarction suggests that during the first 30 days, the prognosis for women may be worse, even after adjusting for age, severity of infarction, and other baseline variables (*BMJ* 1994;309:566-569). At six months, event-free survival was 76.1% for men and 63.3% for women; overall survival was 85% for men and 70% for women. Men received thrombolysis slightly more often, and significantly more men were discharged on beta-blocker therapy. The authors conclude that until women are treated as vigorously as men, the role of gender as a predictor of post-MI outcome cannot be determined.

Colin Kerr, director of the Hamburg (PA) Center for Developmental Disabilities, recently listed **eight under-used therapeutic regimens** that **can have a major impact on morbidity and mortality** in adults (*Am Fam Physician* 1994;50:1497-1504). Criteria included safety, cost effectiveness, substantial data supporting efficacy, and evidence of inconsistent use in clinical practice. The eight regimens are prophylactic aspirin therapy, estrogen replacement therapy, nicotine substitutes as adjunctive therapy in smoking cessation, beta-blocker therapy following myocardial infarction, anti-inflammatory agents for asthma, antidepressant drugs for mild depression, increased fiber intake, and regular exercise.

Case reports and data from drug monitoring programs indicate that the widely prescribed serotonin uptake inhibitor antidepressant **fluoxetine (Prozac) may be associated with extrapyramidal side effects** (*Am J Psychiatry* 1995;152:122-125). Reported reactions include akathisia, ataxia, coarse tremor, dystonia, generalized tremor, opisthotonus, spasms, tardive dyskinesia, torticollis, and trismus. The abnormal movements may occur with standard therapeutic doses (20 mg/day) and may improve or disappear with dosage reduction or discontinuation. Extrapyramidal reactions also have been reported with the serotonin uptake inhibitors paroxetine (Paxil) and sertraline (Zoloft).



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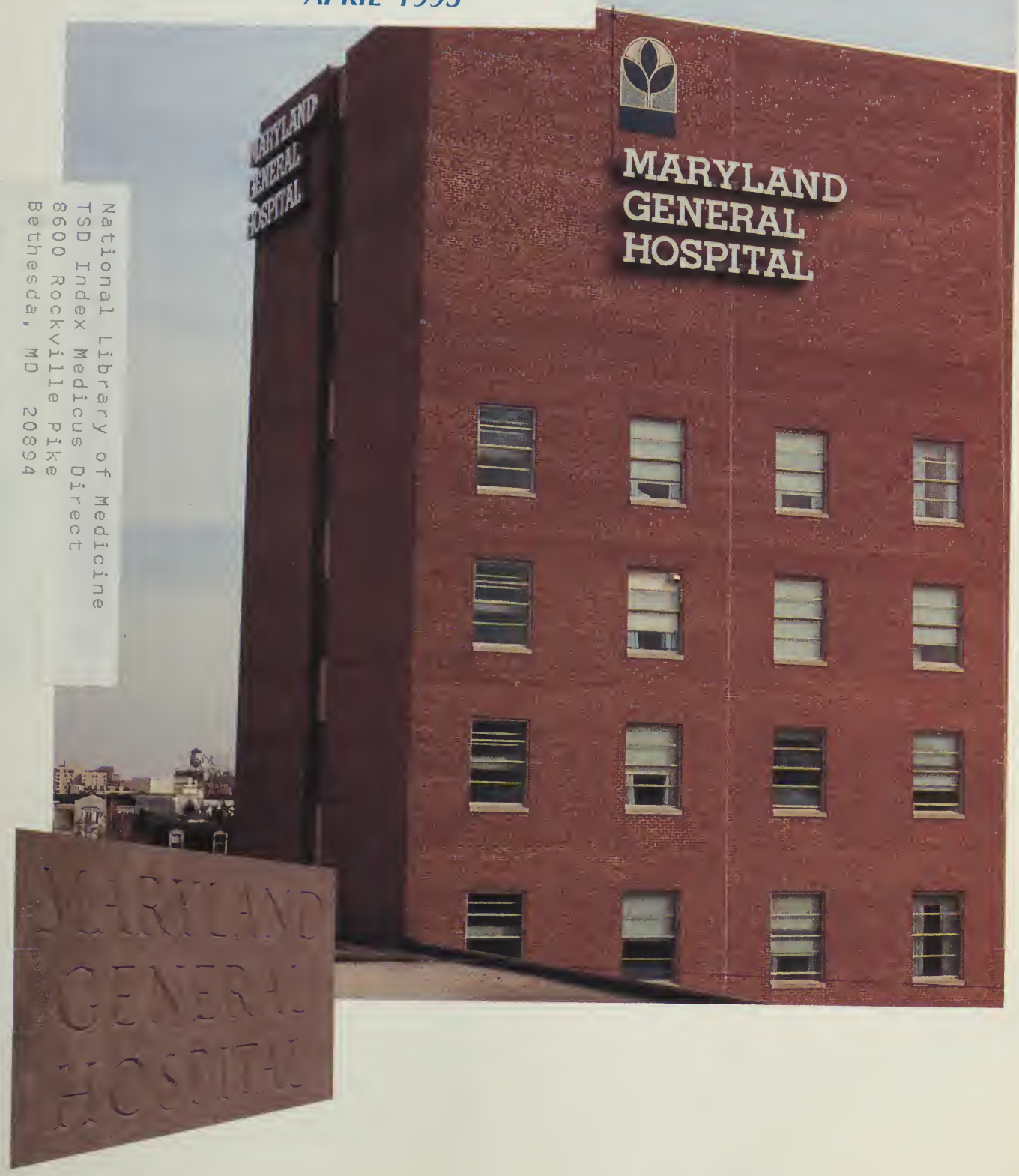
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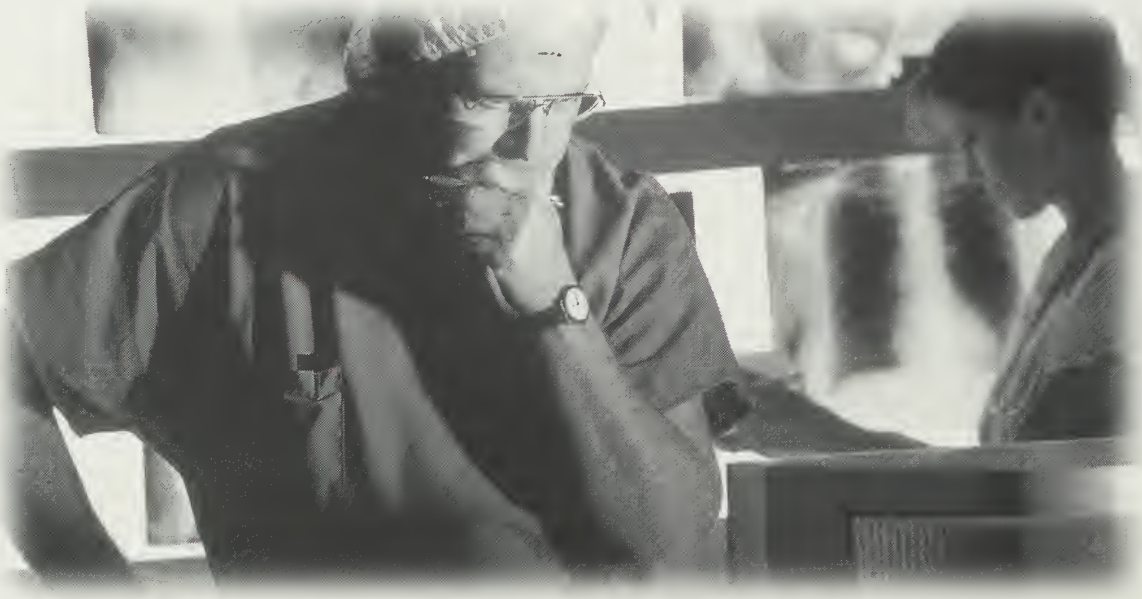
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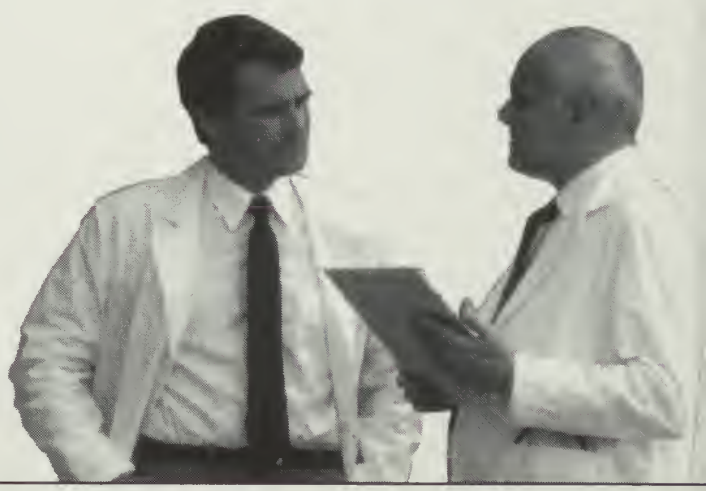
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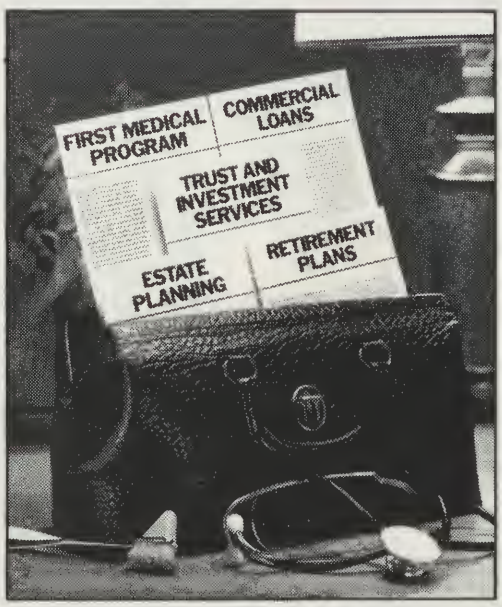
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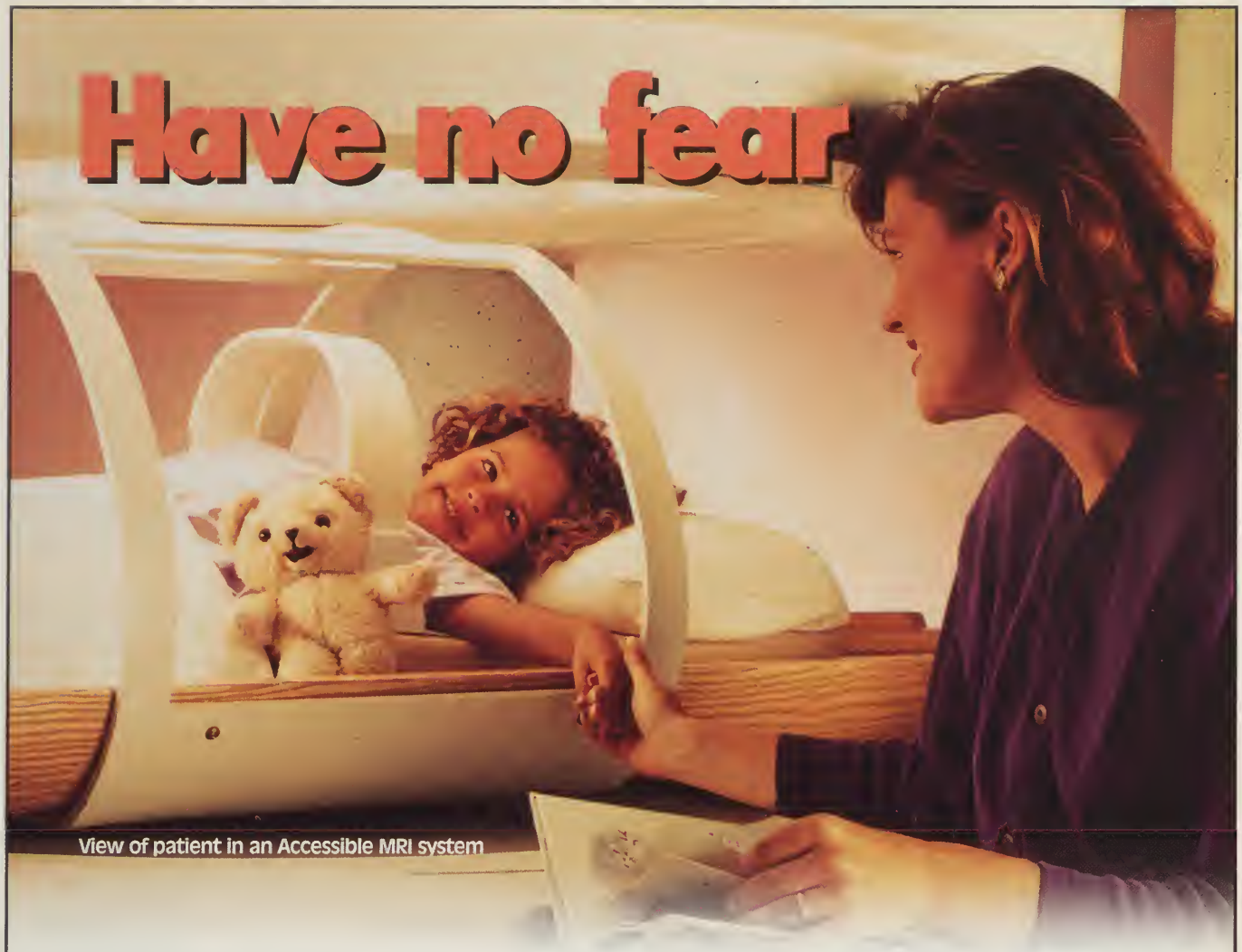
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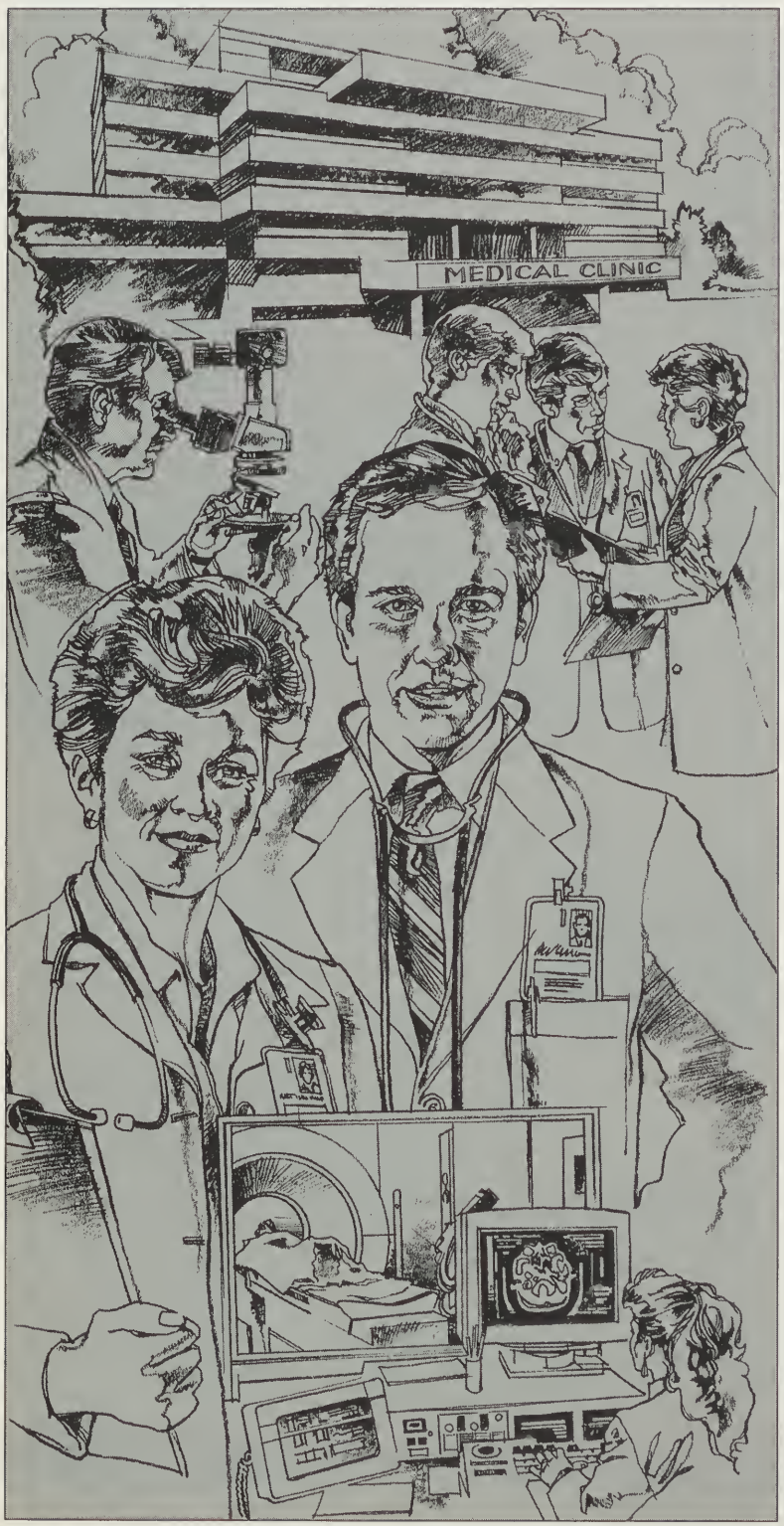
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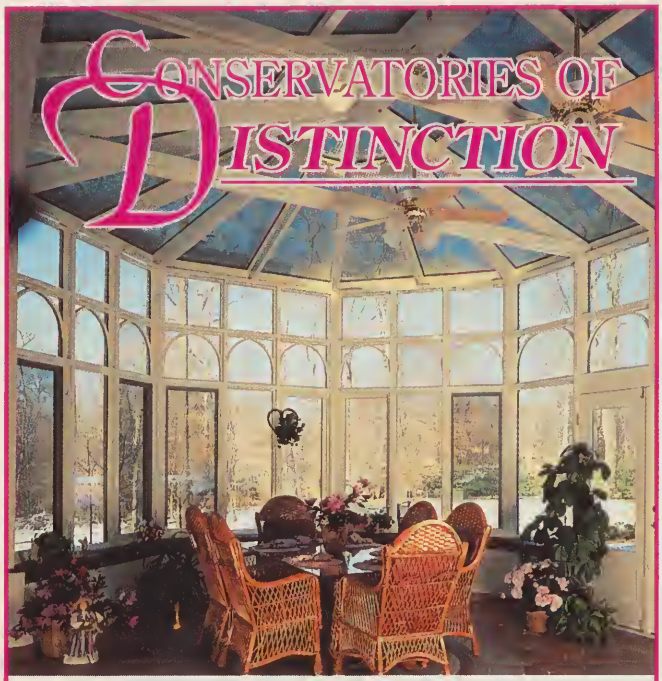
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-5.0%, **6.5%**, and **5.9%** are the 1-year, 5-year, and since inception (3/31/87) average annual total returns, respectively, for the Maryland Tax-Free Bond Fund for the periods ended 12/31/94. **0.7%** and **3.1%** are the 1-year and since inception (1/29/93) average annual total returns, respectively, for the Maryland Short-Term Tax-Free Bond Fund for the periods ended 12/31/94. Present expense limitation has increased the Maryland Short-Term Tax-Free Bond Fund's yield and total return. Figures for both funds include changes in principal value, reinvested dividends, and capital gain distributions. Total returns represent past performance and cannot guarantee future results. Investment return and principal value will vary and shares may be worth more or less at redemption than at original purchase. *Some income may be subject to the federal alternative minimum tax. Income earned by non-Maryland residents will be subject to applicable state and local taxes. Request a prospectus with more complete information, including management fees and other charges and expenses. Read it carefully before you invest or send money. T. Rowe Price Investment Services, Inc., Distributor.

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Annual Meeting Preliminary Program

The preliminary program for the 197th Annual Meeting of the Medical and Chirurgical Faculty of Maryland, "Outcome Studies—Impact on Medical Practice," immediately follows this issue of the *Chief Executive Officer's Newsletter*. The meeting will be held Thursday, May 4, through Saturday, May 6, 1995, at the Inn and Conference Center (formerly Adult Education Center), College Park, MD.

Medicare Update

DME

The 1995 Fee Schedule for durable medical equipment, prosthetics, orthotics and supplies appears in the January 1995 *Region B Medicare Supplier Bulletin, Special Edition*, which was mailed to providers at the end of January. The fee schedule is based on the **beneficiary's residence, not the supplier billing location**.

Limiting Charge

The Social Security Act Amendments of 1994 (Public Law 103-432) **prohibits any billing or collection** of amounts in excess of the limiting charge and requires refunds or offsets against outstanding balances of amounts paid in excess of the limiting charge within 30 days after the date of the notice of violation. If a physician knowingly and willingly bills or collects for services in excess of the limiting charge on a repeated basis or fails to comply with the requirements for adjustments to billed charges or the requirements for refunds, the Health Care Financing Administration (HCFA) may apply sanctions that include civil monetary penalties of up to $2,000 for each instance of overcharging, assessments of up to twice the amount overcharged, and/or exclusion from participation in the Medicare program for up to five years. Explanation of Medicare Benefits (EOMB) will inform beneficiaries of the right to a refund of charges exceeding the limiting charge.

TrailBlazer Health Enterprises, Inc.

For the reporting period February 1 through February 15, 1995, 170 Limiting Charge Exception Reports were produced and mailed to physicians. If physicians have questions regarding these reports, they may call 410-785-1629.

Providers must submit their W9 information to TrailBlazer. TrailBlazer will be mailing another letter to physicians by March 15, 1995, with a due date of 30 days from the date of the letter. If TrailBlazer does not receive a response from the affected physicians, it will be forced to delay processing those physicians' Medicare claims.

Fraud Alert

The Department of Health and Human Services (HHS) Office of Inspector General issued a special fraud alert targeting clinical laboratory services and illegal inducements for referrals that violate the Medicare and Medicaid anti-kickback statute. The alert warned that any time a lab offers or gives a source of referrals for anything of value, it may be viewed as an illegal attempt to induce referrals. Examples of inducements that may implicate the anti-kickback statute are: the lab offers to perform tests for free on the physician's managed care patients in exchange for handling the Medicare and fee-for-service patients; the lab offers

to perform tests on certain patients at below-market rates in exchange for getting the work on other patients at regular rates; the laboratory phlebotomist stationed in a physician's office assists the regular staff during busy times by taking patients' vital signs, filing medical records, or performing tests for the physician's in-office lab; and the lab provides free pick-up and disposal of biohazardous waste unrelated to the lab specimens.

The Justice Department won $411 million in civil fraud settlements last year from health care providers, including $324 million from National Medical Enterprises.

Mammography Guidelines

A new set of clinical practice guidelines for mammography have been published by the Agency for Health Care Policy and Research (AHCPR). The guidelines recommend that women be given the results of their test in writing within 10 days of the examination. Copies of the guidelines and a consumer guide to mammograms are available free from the AHCPR Publications Clearinghouse by calling 1-800-358-9295.

Kentucky Physician Network Approved

The Justice Department informed a group of Kentucky physicians that their plan to form a network to market their services to managed care health plans does not arouse antitrust concerns. The nonexclusive network, Physician Care, Inc., will include about 100 of the 276 physicians in the Bowling Green region. Although the group includes approximately 36% of the physicians, the assistant attorney general noted that the percentage was not substantially greater than the 30% safety zone for nonexclusive physician networks. The network will compete with Center Care, a preferred provider organization sponsored by a local hospital with 173 member physicians.

Disability Review Panel Needed

Montgomery County government and unions representing firefighters and other government workers are seeking physicians board certified in orthopedics, psychiatry, and internal medicine, with experience in disability evaluation, to serve on a disability review panel. Beginning in May, the panel of three physicians will meet in Rockville two evenings per month to review medical records and render medical recommendations concerning employee disability. Compensation will be provided. Interested physicians should contact Carol Rollins at 301-217-2277 or Joyce Clair at 301-217-6910.

Stark II Enforcement Delayed

Enforcement of the Stark II self-referral prohibition (a law prohibiting physicians from making self-referrals for 11 "designated health services," barring them from referring patients to entities to which they have financial links) has been delayed by the federal government. Last month, federal officials announced in a letter that they wouldn't enforce the reporting requirements that took effect on January 1, until a "proper form and accompanying instruction booklet are developed and issued."

Angelo J. Troisi, F.A.C.H.E.
Chief Executive Officer

197th Annual Meeting of the Medical and Chirurgical Faculty of Maryland

Outcome Studies — Impact on Medical Practice

The Inn and Conference Center
University of Maryland
University College

Thursday, May 4, 1995
through
Saturday, May 6, 1995

Preliminary Agenda

General Information

General Information

Please note the information contained in this preliminary program is subject to change. More meetings, events, and continuing medical education activities may be added to the final program, which will be distributed at the meeting.

Continuing Medical Education Credits

The Medical and Chirurgical Faculty of Maryland is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education (CME) for physicians.

The Medical and Chirurgical Faculty of Maryland designates this continuing medical education activity for up to 24.5 hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

Because some educational sessions will be presented concurrently, the maximum number of credits that can be earned by a physician attending this year's meeting is 13.5 CME credits.

Thanks

The Medical and Chirurgical Faculty of Maryland wishes to thank The Med Chi Insurance Agency, *Physician's Practice Digest*, Marion Merrell Dow, Inc., and The Upjohn Company for helping to support the annual meeting's continuing medical education program.

Directions

The Inn and Conference Center (formerly Adult Education Center) is located at the corner of University Boulevard and Adelphi Road in College Park, Maryland.

From Baltimore and points north:
Take I-95 South to the Capital Beltway (I-495) toward College Park. Take exit for U.S. 1 South (Exit 25B). Proceed approximately one mile south on U.S. 1 and turn right onto MD Rt. 193 West. At the third traffic light, turn left onto Adelphi Road. From Adelphi Road, make the first, immediate left onto Campus Drive. The Conference Center will be visible on your left. The parking garage is located next to the Conference Center.

From Bowie/Annopolis areas and points east:
Take MD Rt. 50 to the Capital Beltway (I-95). Go north on I-95 to College Park. Take exit U.S. 1 South (Exit 25B). Proceed approximately one mile south on U.S. 1 and turn right onto MD Rt. 193 West. At the third traffic light, turn left onto Adelphi Road. From Adelphi Road, make the first, immediate left onto Campus Drive. The Conference Center will be visible on your left. The parking garage is located next to the Conference Center.

From Washington, D.C.:
Take George Washington Parkway to I-495 (toward Rockville). Follow I-495 and take the exit for New Hampshire Avenue/Takoma Park (Rt. 650). Go south on New Hampshire Avenue and turn left at the second light (Adelphi Road). Stay on Adelphi Road for approximately three miles (you will go through three traffic lights). At the fourth light, turn left on Campus Drive. The Conference Center will be visible on your left. The parking garage is located next to the Conference Center.

From Montgomery County and points west:
Take the Capital Beltway (I-495) to New Hampshire Avenue/Takoma Park (Rt. 650). Go south on New Hampshire Avenue and turn left at the second light (Adelphi Road.) Stay on Adelphi Road for approximately three miles (you will go through three traffic lights). At the fourth light, turn left on Campus Drive. The Conference Center will be visible on your left. The parking garage is located next to the Conference Center.

Parking

A parking garage is located next to the Conference Center.

Parking is free for hotel guests and meeting attendees. Hotel guests should register at the hotel and receive their parking permit prior to parking in the garage. Meeting attendees who are not staying at the hotel must inform the garage attendant that they are with the Med Chi meeting. The attendant will then give you a dated hang tag that must be displayed in your vehicle while it is parked in the garage. Cars without hang tags will be ticketed!

Hotel Reservations

For room reservations at the Inn and Conference Center, please call 1-301-985-7310 or 1-800-727-8622 and indicate that you will be attending the Med Chi Annual Meeting. Special convention rates are $69 for a single room and $84 for a double room (and 8% tax). **Reservations must be made by April 14, 1995.**

Telephone Messages

During the meeting, messages can be relayed to participants via a message board located at the registration area. The number to call at the Inn and Conference Center is 301-985-7979 and ask for the Med Chi annual meeting desk.

▸ Miscellaneous

For questions regarding the meeting, call 1-800-492-1056 or 1-410-539-0872:

- If your questions are about continuing medical education, call Joan Mannion, ext. 319; or
- For general questions about the annual meeting, call Vivian Smith, ext. 308 or Ruth Seaby, ext. 340.

▸ Support our Exhibitors

Visit the exhibits all day Thursday and Friday. Exhibits are an integral part of the Med Chi annual meeting and a valuable adjunct to the scientific program.

During this year's annual meeting, Med Chi has allocated several specific time periods for physicians to meet one-on-one with exhibitors. By visiting exhibits, you will help ensure that Med Chi continues to receive valuable income that allows us to offer the annual and semiannual meetings.

Med Chi urges you to express your appreciation to exhibitors by visiting their booths and discussing your mutual involvement in patient care.

▸ 1995 Semiannual Meeting

Plan now to attend the Med Chi 1995 semiannual meeting, Friday, September 8 to Sunday, September 10, 1995, at the Princess Royale Resort, Ocean City, Maryland. We hope to see you there!

Special Events

▸ Thursday, May 4, 1995

11:30 am - 12:30 pm

▸ Women in Medicine Luncheon

Join your women colleagues for a networking lunch. This luncheon is open to all women physicians, so invite your associates to attend. Cost is $15.00 and preregistration is required. See registration form.

6:00 pm - 7:00 pm

▸ Welcome Reception

Relax with your colleagues and enjoy drinks and hors d'oeuvres compliments of The Med Chi Insurance Agency. Exhibits will be open during this event.

▸ Saturday, May 6, 1995

8:00 am - 9:30 am

▸ Practice Management Strategies for Young Physicians

Attend this special breakfast meeting compliments of *Physician's Practice Digest*.

Tickets are required to attend this breakfast and must be obtained in advance from the *Physician's Practice Digest* booth in the exhibit area.

No CME credit will be given for this lecture.

8:30 am - 9:30 am

▸ Innovative Concepts for Preserving Your Estate

Attend this special breakfast meeting compliments of the Med Chi Insurance Agency.

Tickets are required for this breakfast and must be obtained from the Med Chi Insurance Agency booth in the exhibit area.

No CME will be given for this lecture.

12:00 noon - 1:30 pm

▸ Maryland Medical Political Action Committee Luncheon Meeting (MMPAC)

Congressional Representatives Robert L. Ehrlich, Jr., Benjamin L. Cardin, Roscoe Bartlett, and Wayne Gilchrest have been invited.

All Med Chi members are encouraged to join MMPAC and attend the luncheon.

This luncheon is $5.00 for MMPAC members; nonmembers may join MMPAC by sending a check for $100 made payable to MMPAC, or may attend by paying $15.00 for the luncheon.

Preregistration is required for this lunch meeting. See registration form.

6:30 pm - 11:00 pm

▸ Presidentiol Banquet honoring J. Richard Lilly, MD

Black Tie Optional

Enjoy dinner and dancing with music by the Zim Zemarel Orchestra. Cost is $60.00. Prereigtration is required. See registration form.

Thursday, May 4 1995

7:30 am - 5:00 pm

▸ Registration/Exhibits open

8:00 am - 10:00 am

▸ Back to the Essentials

Committee on Continuing Medical Education Review (CMERC)

Moderator: *Abdul Nayeem, MD*, Chair, CMERC

Speakers:

Abdul Nayeem, MD
The CMERC and You

Jack Mason, PhD, Dean, Continuing Medical Education, University of Maryland
What are the Essentials Anyway, and What's the Big Deal?

David Solomon, MD, Member, CMERC
CME: Turning Guidelines into Realities

Objectives:
Participating physicians will
- be able to describe the role, function and activities of the CMERC,
- be able to describe the essentials and their requirements, and
- be able to apply the requirements of the essentials to their CME program.

Target Audience: All physicians and administrative staff involved in planning CME activities

CME Credits: 2

8:00 am - 10:00 am

▸ Outcome Studies of Surgical Procedures — Impact on Medical Practice

Committee on Scientific Activity in cooperation with the Department of Surgical Oncology, University of Maryland

Introducer: *Benjamin V. Del Carmen, MD*, Committee on Scientific Activity

Moderator: *E. George Elias, MD, FACS*, President, Maryland Chapter of the American College of Surgeons

Speakers:

Aurelio Rodriguez, MD, FACS
New Horizons in the Evaluation of the Trauma Patient

J. Lawrence Fitzpatrick, MD, FACS
Peptic Ulcer: Medical/Surgical Management

Luis Queral, MD, FACS
The Effect of Endovascular Techniques in Vascular Surgery

E. George Elias, MD, FACS
National Surgical Adjuvant Breast Project: An Update

Objectives:
Participating physicians will be aware of
- advances in the management of trauma patients,
- advances in the treatment of peptic ulcer,
- advances in the treatment of vascular disease, and
- the most recent findings of the National Surgical Adjuvant Breast project.

Target Audience: Family practitioners, internists, surgeons

CME Credits: 2

9:00 am - 10:00 am

▸ Interferons and Cytokines: A Fourth Cancer Treatment Modality

Committee on Scientific Activity in cooperation with the University of Maryland Cancer Center

Introducer: *Howard M. Silby, MD*, Member, Committee on Scientific Activity

Speaker:

Ernest C. Borden, MD, Director, University of Maryland Cancer Center

Objectives:
Participating physicians will be able to
- discuss the production, impact and clinical applications of interferons, hematopoietic growth factors, Interleukin-2 and other cytokines produced as a result of recombinant technology.

Target Audience: Family practitioners, internists and oncologists

CME Credit: 1

10:00 am - 10:30 am

▸ Break — Visit the Exhibits

10:30am - 11:30 am

▸ How Hard Is It to Immunize Teens Against Hepatitis?

Committee on Scientific Activity in cooperation with the Maryland Chapter of the American Academy of Pediatrics

Introducer: *Myron I. Murdock, MD*, Member, Committee on Scientific Activity

Speaker:

Crosson O'Donovan, MD, President, Maryland Chapter of the American Academy of Pediatrics

Objectives:
Participating physicians will be able to
- describe barriers to completion of the series of three immunizations for hepatitis in teenagers,
- identify risk factors in teenage patients who did not complete the series, and
- identify reminders that proved helpful, and those that did not prove helpful, in successfully completing the immunization series with this group.

Target Audience: Family practitioners, internists and pediatricians

CME Credit: 1

10:30 am - 11:30 am

▸ Hormone Replacement for the 90s

Committee on Scientific Activity

Introducer: *Howard M. Silby, MD,* Member, Committee on Scientific Activity

Speaker:
Harrold T. Elberfeld, MD, Associate Director, Department of Obstetrics/ Gynecology, Franklin Square Hospital

Objectives:
Participating physicians will be able to describe
- ▸ what low-dose therapy involves,
- ▸ various regimens,
- ▸ the history of hormone replacement treatments (HRT), and
- ▸ benefits and risks of low-dose HRT.

Target Audience: Family physicians, primary care physicians, obstetricians/ gynecologists

CME Credit: 1

10:30 am - 11:30 am

▸ Three Dimensional Treatment Planning to Improve Care for Radiation Oncology Patients

Committee on Scientific Activity in cooperation with the Johns Hopkins Oncology Center

Introducer: *Henry N. Wagner, MD,* Chair, Committee on Scientific Activity

Speakers:
Lawrence Kleinberg, MD, Radiation Oncology Center, Johns Hopkins Hospital
Michael Herman, PhD, Radiation Oncology Center, Johns Hopkins Hospital

Objectives:
Participating physicians will be able to
- ▸ recognize patients appropriate for referral for three dimensional imaging,
- ▸ describe the use of a three dimensional radiation simulation device in planning radiation therapy that allows more precise delivery of radiation treatment and minimizes toxicity to healthy cells, and
- ▸ describe possible future applications.

Target Audience: Primary care physicians, oncologists, surgeons

CME Credit: 1

11:30 am - 12:30 pm

▸ Women in Medicine Luncheon

Preregistration and an additional fee are required to attend this luncheon. See page P-3 for details.

11:30 am - 12:30 pm

▸ Lunch on your own

12:30 pm - 1:00 pm

▸ House of Delegates Registration

All delegates and alternate delegates must register during this time and be seated by 1:00 pm when the meeting begins.

1:00 pm - 4:00 pm

▸ House of Delegates Meeting

4:00 pm - 4:30 pm

▸ Break — Visit the Exhibits

4:30 pm - 5:00 pm

▸ General Membership Meeting

5:00 pm - 6:00 pm

▸ Heroin and Other Opioids: Use and Abuse

Committee on Scientific Activity

Introducer: *Stanley R. Platman, MD,* Member, Committee on Scientific Activity

Speaker:
N. Joseph Gagliardi, MD, Family Physician, Columbia Medical Plan, and Medical Director of Addictions Services, Green Spring Mental Health Services

Objectives:
Participating physicians will be able to
- ▸ recognize signs and symptoms of opioid abuse and identify clinical procedures for diagnosing opioid abuse,
- ▸ describe treatment options for referring patients who are abusing opioids,
- ▸ identify practices for prescribing opioids responsibly, and
- ▸ recognize and resist patients who seek prescription drugs for abuse or illegal resale.

Target Audience: All physicians

CME Credit: 1

5:00 pm - 6:00 pm

▸ Photorefractive Keratectomy (PRK)

Committee on Scientific Activity in cooperation with the Maryland Society of Eye Physicians and Surgeons

Introducer: *James W. Karesh, MD,* President, Maryland Society of Eye Physicians and Surgeons

Speaker:
Gerri Goodman, MD, Immediate Past President, Maryland Society of Eye Physicians and Surgeons

Objectives:
Participating physicians will be able to describe
- ▸ photorefractive keratectomy (PRK),
- ▸ the results of clinical trials, and
- ▸ benefits and risks of PRK.

Target Audience: Ophthalmologists, family physicians, internists

CME Credit: 1

6:00 pm - 7:00 pm

▸ Welcome Reception

sponsored by the Med Chi Insurance Agency

Exhibits open during this reception. See page P-3 for details.

Friday
May 5
1995

7:00 am - 5:00 pm
▸ Registration/Exhibits open

8:00 am - 10:00 am
▸ Suit Survival/Lessons in Risk Management

Committee on Scientific Activity in cooperation with Medical Mutual Liability Insurance Society of Maryland

(Medical Mutual members who attend this session are eligible for a 5% premium discount on their 1996 medical professional liability renewal policy. A $40 program fee is required for this discount.)

Moderator: *Daniel Kohn, MD,* Staff Physician, Emergency Department, Harbor Hospital Center

Speakers:
Daniel Kohn, MD
Beth Petree, JD
Scott Sonntag, Esq.

Objectives:
Participating physicians will be able to
- identify current patient care issues as they relate to risk management concerns,
- understand risk management principles through examination of case studies of medical diagnostic and treatment options,
- understand the litigation process and how to deal with aspects of a lawsuit, and
- discuss the application of risk management recommendations.

Target Audience: All physicians

CME Credits: 2

9:00 am - 12:00 noon
▸ Reference Committees

12:00 noon - 1:00 pm
▸ Lunch on your own

1:00 pm - 3:00 pm
▸ Plenary Session — Harnessing the Winds of Change

Committee on Scientific Activity

Introducer: *Donald H. Dembo, MD,* President, Medical and Chirurgical Faculty of Maryland

Keynote Address:
Lonnie Bristow, MD, President-elect, American Medical Association
Donald T. Lewers, MD, Board of Trustees, American Medical Association

Objectives:
Participating physicians will better understand
- federal and state legislative issues that affect the practice of medicine and managed care,
- educational issues, and
- the role of allied health professionals in patient care.

Target Audience: All physicians

CME Credits: 2

3:00 pm - 4:00 pm
▸ Break—Visit the Exhibits

3:00 pm - 4:00 pm
▸ Violence in the Emergency Department

Committee on Scientific Activity in cooperation with the Maryland Chapter, American College of Emergency Physicians

Introducer: *Daniel Kohn, MD, FACEP,* President, Maryland Chapter, American College of Emergency Physicians

Speaker:
Julie Ann P. Cassani, MD, MPH, FACEP, Director, The Johns Hopkins Hospital Advanced Life Support Transport; Assistant Professor, The Johns Hopkins University School of Medicine

Objectives:
Participating physicians will
- become aware of the current experience with emergency department violence,
- become familiar with the potential experience of emergency department violence,
- learn how to protect themselves, their patients and their emergency departments from incidents of violence.

Target Audience: Emergency physicians.

CME Credit: 1

4:00 pm - 5:00 pm
▸ Recent Advances in Burn Care

Committee on Scientific Activity in cooperation with the Baltimore Regional Burn Center

Introducer: *Henry N. Wagner, MD,* Chair, Committee on Scientific Activity

Speaker:
Andrew M. Munster, MD, Director, Baltimore Regional Burn Center

Objectives:
Participating physicians will be able to describe
- recent improvements in burn care, particularly in the areas of triage, transportation, resuscitation, infection control and rehabilitation, and
- the methodology for studying burns outcome in terms of mortality rates, utilization of resources and quality of life measurements.

Target Audience: Primary care physicians, emergency physicians, and administrators.

CME Credit: 1

4:00 pm - 6:00 pm
▸ The Clinical Application of Cardiovascular Research

Committee on Scientific Activity in cooperation with the American Heart Association, Maryland Affiliate

Moderator: *Stephen S. Gottlieb, MD,* University of Maryland School of Medicine

Speakers:
David Thiemann, MD, The Johns Hopkins University School of Medicine
The Effect of Outcomes Research on the Management of the Cardiac Patient

Peter Vaitkevicius, MD, Johns Hopkins Bayview Medical Center
Exercise and Heart Failure

Lawrence J. Appel, MD, MPH, Welch Center for Prevention, Epidemiology and Clinical Research
Patassium Supplementatian as a Methad af Preventing/Reducing High Blaad Pressure

Roger S. Blumenthal, MD, The Johns Hopkins University School of Medicine
Results af the Scandinavian Simvastatin Survival Study

Keynote Address

Lonnie Bristow, MD

Dr. Bristow, an internist from San Pablo, California, was elected president-elect of the American Medical Association (AMA) in June 1994. A member of the AMA Board of Trustees since 1985, he has served as chair of the Board of Trustees from 1993 to 1994, as vice-chair from 1992-1993, and as a member of the Executive Committee since 1990. He represented the AMA as a commissioner to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) from 1990 to 1993, and his service on the AMA Education and Research Foundation includes serving first as its secretary-treasurer from 1986 to 1988, and then as its president from 1988 to 1990.

Before his election to the Board in June 1985, Dr. Bristow served as an alternate delegate and as a delegate to the AMA House of Delegates from the American Society of Internal Medicine. In 1979, he became a member of the AMA's Council on Medical Service, which he chaired from 1983 until his election to the Board of Trustees.

Dr. Bristow has long been active in organized medicine. Among the positions he has held are chair of the Section on Internal Medicine of the California Medical Association and president of the California Society of Internal Medicine and later, president of the American Society of Internal Medicine. He was also honored in 1977 by his election to membership in the Institute of Medicine of the National Academy of Sciences.

Dr. Bristow's service in the professional community has been and continues to be diverse as illustrated by his appointment to serve on the Institute of Medicine's Committee on the Effects of Medical Professional Liability of the Delivery of Maternal and Child Health Care from 1987 to 1989, his appointment by the Surgeon General to serve on the Federal Interagency Committee on Smoking and Health in 1988, and his appointment by the Secretary of Health and Human Services to serve on both the Center for Disease Control's HIV Prevention Advisory Committee and the 1989 Quadrennial Advisory Council on Social Security.

Born April 6, 1930, Dr. Bristow received his BS degree from the College of the City of New York in 1953 and his MD degree in 1957 from New York University College of Medicine. He completed his internship in 1958 at San Francisco City and County Hospital and served his residency in internal medicine at U.S.V.A. Hospital, San Francisco, Francis Delafield Hospital (Columbia University Service) New York City, and U.S.V.A. Hospital, Bronx, New York. In 1981 he completed an additional residency in occupational medicine at the University of California, San Francisco, School of Medicine. Dr. Bristow is a diplomate of the American Board of Internal Medicine and a fellow of the American College of Physicians. He is on the staff of Brookside Hospital, San Pablo, California.



Dr. Bristow has written and lectured extensively on medical sciences as well as on socioeconomic and ethical issues related to medicine. He currently serves as a reviewer for The Journal of the American Medial Association.

Dr. Bristow and his wife, Marilyn, reside in Walnut Creek, California, and are the parents of two children.

Objectives:
Participating physicians will be able to discuss
- recent breakthroughs in cardiovascular research,
- areas of research currently under investigation, and
- some clinical applications of recent research.

Target Audience: Family practitioners, obstetricians/gynecologists, cardio/thoracic surgeons, internists, pediatricians, preventive medicine specialists and public health physicians

CME Credits: 2

5:00 pm - 6:00 pm

▸ Common Mistakes in Emergency Department Management of Occupatianal Injury and Appropriate Use of an Occupational Medicine Clinic

Committee on Scientific Activity in cooperation with the Maryland Chapter, American College of Emergency Physicians

Introducer: *Jur T. Strobos, MD, JD, FACEP,* Director, Research Policy Staff, Office of Policy, Food and Drug Administration

Speaker:
Clifford S. Mitchell, MS, MD, MPH, Instructor, The Johns Hopkins University, School of Hygiene and Public Health

Objectives:
Participating physicians will
- better understand the legislation governing occupational health, including the 1970 OSHA Act and Maryland regulations,
- become familiar with standards that can affect the initial assessment, management, and disposition of patients, including the Hazard Communication standard (Right to Know), and specific standards on particular hazards, and
- become aware of physician reporting requirements for certain occupational illnesses.

Target audience: Emergency physicians, occupational medicine physicians.

CME Credit: 1

Saturday

May 6

1995

7:30 am - 2:00 pm

▸ Registration open (no exhibits)

8:00 am - 9:30 am

▸ Practice Management Strategies for Young Physicians

Admission to this breakfast is by ticket only. Tickets must be obtained in advance from the *Physician's Practice Digest* booth in the exhibit area. Seating is limited to 25 people. This breakfast is compliments of *Physician's Practice Digest.*

Introducer: *M. Michael Massumi, MD,* Chair, Med Chi Committee on Young Physicians

Speakers:

Michael Hodes, Esq., Partner, Hodes, Pessin, and Katz

Charlotte Kohler, Principal, Kohler Health Care Consultants

This session will address practice start-up issues (e.g., negotiating strategies, business contracts, loan consolidation) and operational issues (e.g., leasing space, hiring personnel, marketing, referrals).

CME Credit: None

8:30 am - 9:30 am

▸ Innovative Concepts for Preserving Your Estate

Admission to this breakfast meeting is by ticket only. Tickets must be obtained in advance from the Med Chi Insurance Agency booth in the exhibit area. Seating is limited to 40 people.

CME Credit: None

9:30 am - 10:00 am

▸ Public Health Update from the Secretary of Health and Mental Hygiene

Introducer: *Henry Wagner, MD,* Chair, Committee on Scientific Activity

Speaker:

Martin Wasserman, MD, JD, Secretary of Health and Mental Hygiene

Objectives:

Participating physicians will

- be familiar with health initiatives undertaken in the first months of Governor Glendenning's administration, and
- health-related legislation considered during the 1995 Maryland legislative session.

Target audience: All physicians

CME credit: 0.5

10:00 am - 11:00 am

▸ Overview of Retinoids in Dermatology

Committee on Scientific Activity in cooperation with the Maryland Dermatologic Society

Introducer: *Margaret Weiss, M.D,* President, Maryland Dermatologic Society

Speaker:

Gary L. Peck, MD, Director of Clinical Research, Department of Dermatology, Washington Hospital Center

Objectives:

Participating physicians will be able to describe

- the use of retinoids in the treatment of cystic acne, psoriasis and other dermatologic conditions, and
- the side effects of the retinoids.

Target Audience: Dermatologists, family practitioners

CME Credit: 1

10:00 am. - 12:00 noon

▸ Production and Reproduction

Committee on Scientific Activity in cooperation with the Maryland Asthma and Allergy Society

Moderator: *John Bacon, MD,* President, Maryland Asthma and Allergy Society

Speakers:

Michael Blaiss, MD, Associate Professor of Pediatrics, Assistant Professor of Medicine, Director, Pediatric Allergy/Immunology Training Program, University of Tennessee, Memphis, Tennessee

The Role of Outcome Studies in Allergy and Clinical Immunology

Objectives:

Participating physicians will

- be able to identify specific outcome measures as they apply to allergic disease and asthma,
- understand the specific parameters and tools employed, and
- understand the medical/medico-economic implications of such studies.

Norbert Gleicher, MD, Director of Reproductive Immunology, The Center for Human Reproduction, President, The Foundation of Reproductive Medicine, Chicago, Illinois

Overview of Reproductive Immunology

Objectives:

Participating physicians will

- be able to discuss current concepts of reproductive immunology,
- be able to identify those factors that can contribute to reproductive failure, and
- be familiar with treatments being developed.

Target Audience: Family practitioners, internists, allergists, pulmonologists, pediatricians, endocrinologists, obstetricians/gynecologists

CME Credits: 2

10:00 am - 12:00 noon

▸ Physicians and the Tobacco Epidemic

Committee on Scientific Activity in cooperation with the Smoke Free Maryland Coalition

Introducer: *Martin Wasserman, MD, JD,* Secretary of Health and Mental Hygiene

Speakers:

W. Clinton McSherry, PhD, Clinical Research Fellow, Division of Pulmonary and Critical Care Medicine, The Johns Hopkins University School of Medicine

Treating Nicotine Addiction: The State of the Art and Beyond

Objectives:
Participating physicians will
- be able to describe the behavioral and psychological aspects of nicotine addiction, and
- be familiar with current and developing treatment options for nicotine addiction.

Rex D. Archer, II, MD, MPH, Health Officer for Garrett County, President, Maryland Association of County Health Officers

Preventing Addiction to Nicotine Before, During and After the Medical Visit

Objectives:
Participating physicians will
- be able to describe a range of creative approaches they can use, both in and out of the office, to prevent nicotine addiction in their patients, and
- be able to describe community level opportunities for preventing nicotine addiction.

Eva M. Smorzaniuk, MD, President, Talbot County Medical Society

Talbot County: A Case Study in Successful Physician Activism

Objectives:
Participating physicians will
- be able to describe how local physicians on Maryland's Eastern Shore fought the tobacco industry and won clean indoor air legislation for their county, and
- see and hear the pro-health messages developed and aired in this successful initiative.

Target Audience: All physicians

CME Credits: 2

12:00 pm - 1:30 pm

▸ Maryland Medical Political Action Committee Luncheon Meeting

Congressional Representatives Robert L. Ehrlich, Jr., Benjamin L. Cardin, Roscoe Bartlett, and Wayne Gilchrest have been invited.

Preregistration and an additional fee are required to attend this luncheon meeting. See page P-3 for details.

12:00 pm - 1:30 pm

▸ Lunch on your own

1:30 pm - 2:00 pm

▸ House of Delegates Registration

All delegates and alternate delegates must register during this time and be seated by 2:00 pm when the meeting begins.

2:00 pm - 5:00 pm

▸ House of Delegates Meeting

6:30 pm - 11:00 pm

▸ Presidential Banquet

honoring J. Richard Lilly, MD

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Preregistration and an additional fee are required to attend this function. See page P-3 for details.

Members of the Committee on Scientific Activity

Henry N. Wagner, MD, Chairperson

Benjamin V. Del Carmen, MD

Victor R. Hrehorovich, MD

Myron I. Murdock, MD

David A. Nagey, MD

Terrence P. O'Brien, MD

Stanley R. Platman, MD

Howard M. Silby, MD

Robert L. Yin, MD

Registration Form

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Check all that apply

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Event Preregistration (See page P-3 for details on these events.)

▸ **Women in Medicine Luncheon**
Thursday, May 4, 1995 11:30 am - 12:30 pm

▷ I need _____ tickets at $15.00 each _____

▸ **MMPAC Luncheon**
Saturday, May 6, 1995 12:00 noon - 1:30 pm

▷ MMPAC Member — $5.00 _____

▷ Non-MMPAC Member

▷ I want to join MMPAC
($100 check made payable to *MMPAC* enclosed) _____

▷ I wish to attend this luncheon only — $15.00 _____

▸ **Presidential Banquet**
Saturday, May 6, 1995 6:30 pm - 11:00 pm

▷ I need _____ tickets at $60.00 each _____

▸ **Total charges** _____

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Baltimore psychiatrist **Frank J. Ayd, Jr., M.D.,** is the author of *Lexicon of Psychiatry, Neurology, and the Neurosciences*, published in January by Williams & Wilkins. A professor of psychiatry at West Virginia University School of Medicine and emeritus director of professional education at Taylor Manor Hospital in Ellicott City, Dr. Ayd is the editor of *International Drug Therapy Newsletter.*

The third edition of *The Pharmacologic Approach to the Critically Ill Patient* was published by Williams & Wilkins in 1994. The editor, **Bart Chernow, M.D., F.A.C.P.,** is professor of medicine, anesthesia, and critical care at The Johns Hopkins University School of Medicine; physician-in-chief at Sinai Hospital of Baltimore; and editor-in-chief of the journal *Critical Care Medicine.*

Johns Hopkins physicians **Lisa Cooper-Patrick, M.D., M.P.H., Rosa M. Crum, M.D., and Daniel E. Ford, M.D., M.P.H.,** developed a four-question survey that may help nonpsychiatrists screen patients for suicidality. A report on the questionnaire was published in *JAMA* (1994;272:1757-1762).

Robert Vogel, M.D., director of cardiology at University of Maryland Medical Center, is the author of a study that found considerable variation among three sets of guidelines for cardiac disease treatment. Results of the study were presented in Dallas last year at the 67th Scientific Sessions of the American Heart Association.

Kurt Kroenke, M.D., of the Uniformed Services University of Health Sciences, was co-author of a report published in *JAMA* (1994;272:1749-1756) describing a new test that may help primary care physicians diagnose previously undetected mental disorders in their patients.

Lee H. Harrison, M.D., of the Johns Hopkins University School of Hygiene and Public Health, wrote an editorial to accompany a lead *JAMA* article (1995;273:419-421) on the apparently increasing incidence of group C meningitis in the United States.

Kenneth Johnson, M.D., head of the department of neurology at University of Maryland Medical Center, is the coordinator of a national, placebo-controlled study of a new drug, Copolymer 1, that may reduce the incidence of relapse in patients with mild to moderate multiple sclerosis. Preliminary results of the study were presented in San Francisco last October at the meeting of the American Neurological Association.

Michael Miller, M.D., director of preventive cardiology at University of Maryland Medical Center, was a co-investigator in a study that found the antiepileptic drug Dilantin may raise levels of high-density lipoprotein-cholesterol. Results of the study were presented in Dallas last year at the 67th Scientific Sessions of the American Heart Association.

David Schwartz, M.D., Ph.D., assistant professor of molecular microbiology and immunology at the Johns Hopkins School of Hygiene and Public Health, is the lead investigator of a group that has studied for several years a long-time HIV-infected woman who has never developed AIDS-related diseases. Their report was published in the December 1994 issue of *AIDS Research and Human Retroviruses.*

Homayoon Farzedegan, Ph.D., associate professor of infectious disease epidemiology at the Johns Hopkins School of Hygiene and Public Health, is the lead author of a 10-year study of the timing of immune responses and the development of AIDS in HIV-positive men. Results of the study were presented at the Second National Conference on Human Retroviruses and Related Infections, held in Washington, DC, in January.

Peter Vaitkevicius, M.D., a cardiologist at University of Maryland Medical Center, was the lead researcher in a study that found supervised aerobic exercise may benefit elderly men with congestive heart failure. Study details were presented in Dallas last year at the 67th Scientific Sessions of the American Heart Association.

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Speak Out

April 1, 2001

Health care 2001: gambling with health care finally pays off

The health care crisis is finally over. It ended when Donald Trump and the gambling industry took over from the insurance industry. Health care is now available to anyone who wants it, and it's free as long as you play. For those who have not kept up with the rapid changes in health care, a short review of developments over the past few years may be helpful.

It turns out that the crisis was not really due to a shortage of health services or that it cost too much. It was mostly over the amount of money that could be made and about who was going to get it. Nearly everyone agreed that doctors did not understand money and did not deserve to have it or even handle it. The public understood money even less and needed someone to manage it for them.

Politicians fought with the insurance industry for control and insurance companies battled with each other for market shares. It was like a bunch of dogs fighting over a bone. Some observers believed that a *genuine* health care crisis was actually created as the health care system was torn apart by the struggle. Everyone agreed that health care would never be the same.

Insurance executives say they did a lot of good. Others aren't so sure. It is true that discipline was imposed on the system. Health care rationing was made palatable to the public by giving it different names, such as *managed care, health maintenance, capitation,* and *free choice*. Other names were changed, too. There were no more doctors or patients. They were relabeled *providers* and *consumers*. Doctors, nurses, social workers, technicians, and all other health care workers were lumped together as "providers." This made them interchangeable and saved a lot of money that could go into profits for the insurance companies. As *consumers*, patients were *empowered* to make choices between health care *packages* without understanding the contents.

Health insurance companies' profits skyrocketed, while doctors' incomes plummeted. Doctors burned out, patients burned up, and hospitals closed down. If patients were displeased with empty *packages*, they took out their anger on doctors for lack of more accessible targets. Patient dissatisfaction

Reprints: *Gerald D. Klee, M.D., 28 Allegheny Avenue, Suite 1300, Towson, MD 21204*

gave the insurance companies an excuse to further reduce doctors' fees, which resulted in still more profits for the insurance companies.

Biological evolution did not end with *Tyrannosaurus rex* and health care evolution did not end with health insurance companies and HMOs. These organizations dominated the landscape for a while, but they made some fundamental blunders, which set the stage for their demise. Their biggest mistake was in ignoring, or not knowing, Trump's Rules, which are as follows:

1. **Don't tell people what they need, give 'em what they want.**
2. **Make everyone feel like a winner.**

The insurance companies and HMOs gave no one what they wanted and made everyone feel like losers.

Trump saw his chance and moved in. His thinking on the subject is described in his recent best-selling book, *You Bet Your Life*. Trump reminds us that everything in life is a gamble, starting with which sperm will reach the egg. Taking chances is unavoidable, and we take them with every move we make. The best we can do is play the odds. Humans have adapted to this uncertainty in life in various ways and have even learned to enjoy it by making bets. People like excitement and thrills—even to flirt with danger—but they also want security.

As Trump's argument goes: Although insurance is advertised as a way of buying security, it is in fact a form of gambling that may *offer* a sense of security. In insurance, as in casinos, the player bets against the house. In life insurance, policy holders bet they will expire before the policy does, while the company (the "house") bets they won't. In health insurance, policy holders bet they will need medical care costing more than the premium; the insurance company bets they won't need it, or at least that the company can avoid paying for it. The insurance industry is, in effect, a large gambling enterprise that represents itself as a quasi-public utility. The industry has been successful because of a combination of actuarial, financial, marketing, and political skills.

According to Trump, these capabilities, although impressive, are no match for those of the gaming industry. The gaming industry has a far better understanding of human motivations and behavior than the insurance industry (or the medical profession, for that matter). Both the insurance industry and the medical profession attempt to tell people what they *need*. Trump knows what people *want*. Trump knows people want excitement. They want to take chances, but to feel safe while doing so. He knows that people want

Speak Out

to live recklessly while having the safety net of free health care. He will give them what they want. No one should complain if he enriches himself and his partners while doing so.

Trump's health care financing plan took the industry by storm. Adding to his gambling establishment, he opened the "Taj Mahal Health and Gaming Resort" with headquarters in Atlantic City. He made health coverage automatic for anyone who plays, and for as long as they play. One can play roulette, blackjack, slot machines, craps, or any other game in the house. It's all the same. Win or lose, the coverage is in proportion to amounts wagered. (A small percentage of sums wagered goes into the health care account.) As long as you play, you can never lose your health coverage. And you still have a chance to win the jackpot.

Trump promotes his painless method of financing health care with slogans such as, "Don't get sick, get lucky!"

After Trump added his health care package to the Taj Mahal operation, a revolution in health care financing took place almost overnight. Thousands of people from surrounding areas dropped their health insurance and headed for Atlantic City. Gambling facilities strained under the onslaught, but were rapidly expanded.

As other gaming organizations followed Trump's example, new facilities were established in Atlantic City and Las Vegas, on riverboats, ships at sea, and in states throughout the nation. Whatever your favorite game of chance, you can now play it and get free health coverage. Indian reservations, which already had legalized gambling, have expanded their facilities and now offer free Native American health care for those who play. Home shopping networks have joined in by adding gambling channels. For those who are housebound or prefer to stay at home for any reason, it is now easy to play on interactive television, 24 hours a day, 7 days a week, and gain health coverage while doing so.

Casinos overcame people's moral objections to gambling by donating some of the profits to charity or to other good causes. One week would be "Cancer Week," in which a fraction of each dollar wagered would go for cancer research; another week would be for AIDS research, or for the homeless. These charitable contributions are highly advertised and enable people to feel virtuous as they play.

Doctors rushed to join the system. There was no red tape and no paperwork. In order to be *providers*, they merely had to play at the gambling tables. A remark by a well-known medical leader is often quoted: "Even if

Speak Out

health care these days is just a crap shoot, now at least there's a chance of winning something." Your best chance of finding a doctor now is at a casino.

Medical school courses on managed health care have been replaced by courses on gambling and health care. They are the only classes in which students always stay awake.

As the gaming industry took over health care, the health insurance industry collapsed. Victims of their own misjudgment of human nature, they quickly lost their contracts and went into the red. Down but not out, health insurance companies and HMOs had huge cash reserves gained during the preceding years. With these resources they bought into the gaming industry and in the process drove the price of shares through the ceiling. Wall Street went wild with joy.

Trump cites recent studies conducted by the Taj Mahal Institute for Medical Research showing clinics and hospitals to be half empty: most doctors and patients would rather spend their time at the gaming tables. Ever since *managed care* set the standard by allowing a maximum of twenty minutes for any type of surgery, from ingrown toenails to kidney transplants, many people believe that their chances at the gambling table are better than they are on the operating table.

Every advance in human society has its opponents. There are some voices from the medical field and elsewhere that denounce Trump's system as evil and corrupt. They say we are rapidly going to hell. Trump reminds us that under *managed care* we were heading for hell anyway. Under his system, at least we can enjoy the trip.

Perhaps things could be done in better ways. Perhaps the time will come when human affairs are governed by benevolence and wisdom rather than by greed and folly.

Perhaps.

But don't bet on it.

GERALD D. KLEE, M.D.
Towson, Maryland ■

LETTERS TO THE EDITOR

Competency assessment and attorneys: to consult or not to consult?

The article in the February issue by Dr. Janofsky, "Competency assessment of medical and psychiatric patients under Maryland's Health Care Decisions Act" (*Md Med J* 1995;44:105–116), was useful and informative. As someone who was involved in the legislative genesis of the HCDA, I wish to add some comments.

The HCDA was legislated after seven years of effort because the Maryland circuit court judges not only wanted guidance by the General Assembly, but because the judges believe these decisions are best made without judicial involvement in most cases. In his article, Dr. Janofsky makes frequent suggestions to consult the legal office or an attorney, when the intent of the General Assembly was that attorneys be less involved than before the HCDA was enacted. For example, the affidavit required so that a "close friend" can be a surrogate is available at most facilities, does not need notarization, and is meant to be used without needing an attorney.

Each hospital and many nursing homes now have patient care advisory (PCA) committees. One of the abilities of the committees is to advise patients and providers of the proper use of the HCDA and facilitate communication. Many situations in which Dr. Janofsky suggests obtaining legal advice are more properly the jurisdiction of a PCA committee. Indeed, the HCDA calls for the judge to consult a PCA committee in certain cases, such as a dispute among the same class of surrogates.

My experience has been that attorneys are not comfortable with the HCDA and frequently render a literal and impractical interpretation.

Dr. Janofsky does not mention that physicians are not obligated to provide a medically ineffective treatment, regardless of a patient's or family's wishes, subject to provisions in the HCDA. That subject is larger than the present article; once again, the PCA committee has expertise in this area.

Indeed, the HCDA is complex, but it is also meant to provide guidance to patients, families and friends, and providers. When it is confusing to apply, the proper resource is a facility's PCA committee, not the facility's attorney.

DAVID D. DAVIS, M.D., J.D.
Severna Park, Maryland

Dr. Janofsky replies

I could not agree more with Dr. Davis. A clinical perspective is extremely important in assessing clinical competency. Due to the complexity of the Health Care Decisions Act, legal advice is, unfortunately, occasionally necessary. It has been my experience that an attorney schooled in health care law is helpful in interpreting the HCDA. I always make it a point, however, not to follow an attorney's advice blindly, but to put that advice into clinical perspective.

JEFFREY S. JANOFSKY, M.D.
Director, Psychiatry and Law Program, The Johns Hopkins University School of Medicine ■

Memo

To: **President Clinton**
Members of the House and Senate

From: **The 300,000 member physicians of the American Medical Association**

Re: **Getting the job done on health care**

We believe there are several workable measures that can be passed now to help achieve our ultimate goal – making quality health care affordable and accessible to all Americans.

As the country awaits the State of the Union address, the member physicians of the American Medical Association set forth these practical recommendations to improve health care for our patients.

Insurance Reform – Pass insurance reforms that will make sure Americans will not lose their coverage if they change jobs or get sick.

Medicare Reform – Reform our Medicare system so it will be there for the next generation of elderly and disabled.

Medical Savings Accounts – Make MSAs available so people can pay for routine medical care with pre-tax dollars.

Patient Protections – Enhance patient choice, disclosure and assure greater physician involvement in corporate decisions about patient care.

Liability Reform – Enact meaningful liability reform to ensure fair compensation to patients with legitimate claims while eliminating excessive malpractice awards that lead to defensive medicine.

Regulatory Relief – Free both physicians and patients from the ever-increasing burden of needless and wasteful paperwork, regulations, obsolete anti-trust rules and red tape.

Medical Education and Research – Protect medical education and research so that we can find cures for killers like AIDS and cancer.

Public Health Problems – Fight social problems like violence and smoking — problems that cost billions of dollars and millions of lives.

These measures are sensible things we can do now that will make a difference for all of us. So, as we begin our nation's 104th Congress, we renew our pledge to the health of America. As the voice of the medical profession, we pledge to do everything we can to help make these things happen. It is <u>our</u> contract with America, and we fervently hope that every American will join us.

American Medical Association
Physicians dedicated to the health of America

An historical overview of Maryland General Hospital

Ruth Doerfler-Evans, R.N., B.A., CNOR

Ms. Doerfler-Evans is clinical manager of the operating room at Maryland General Hospital in Baltimore, USA.

The early years

Maryland General Hospital, a private, nonprofit, acute care, urban medical center opened its doors in 1881 as a teaching hospital for medical students. Established by a group of Baltimore physicians as a training facility with the Baltimore Medical College, MGH housed fifty beds with a dispensary for private and charity patients.

In 1888, a maternity ward opened next to the main hospital building on Linden Avenue, and a college building was constructed on Howard Street. In 1893, however, tunnel construction for the Baltimore & Ohio railroad caused structural damage to the Howard Street building, and a new building was built at the corner of Linden Avenue and Madison Street. Three years later, the dental building, adjacent to the main hospital, was completed.

In the early years of operation, all hospital beds were located in wards with the exception of one private room. Hospital rates were $5 to $10 per week; medical training expenses were $105 per week. One section of the hospital served poverty-stricken patients, and the Baltimore city government paid the hospital $3 weekly for each patient's care.

The nursing school, founded in 1891, remained in operation for ninety-six years. In 1921, construction was begun for a new building with a dormitory addition for fifty nurses. During its many years of operation, the school enjoyed a notable reputation for training capable, high quality nurses. It was closed in 1987, however, due to changes in the nursing community and changed requirements for educating nurses.

Although MGH was well known for its charity work, a disproportionate number of charity cases caused expense and cash flow difficulties. In 1901, the Baltimore Medical College turned the management of the hospital over to the Sisters of Charity, who operated the hospital for the next ten years.



Courtesy of Maryland General Hospital

In 1911, the Baltimore Medical College merged with the University of Maryland School of Medicine. That same year, the Methodist Church assumed operation of MGH. All properties, including the dental school, were put under the management of representatives of The Methodist Hospital Association: the Methodist Episcopal Church, the Methodist Episcopal Church South, and the Methodist Protestant Church.

The Methodist Hospital Association raised almost three thousand dollars for property renovations, which included the medical and dental college buildings. The hospital's ministry was nonsectarian, offering admission to all people regardless of their religious faith or ability to pay. The hospital was supported by patient revenues, appropriations from the city and state, and gifts from friends.

Among the many physicians who played a critical role in the success of MGH were members of the Lumpkin family. Thomas Morgan Lumpkin, born in Virginia September 12, 1864, moved to Baltimore in 1888 to study medicine at the Baltimore Medical College and later, at MGH. Dr. Lumpkin started his private practice at 640 West Barre Street. Five years later, he moved to 602 South Paca Street, where he practiced for twenty years. He then moved to 826 North Carrollton Avenue, practicing there for nine years. During his many years of practice, Dr. Lumpkin relied on MGH to care for his patients.

Following in his father's footsteps was Dr. Morgan Leroy Lumpkin. Born in Baltimore October 28, 1894, he was the eldest of four sons. After attending public school in Baltimore, he earned a bachelor of science degree in philosophy at Bethany College in West Virginia and in 1919, his medical degree from the University of Maryland. He received his clinical training at MGH and completed postgraduate medical studies in Germany. When he returned to the United States, he became associated with Dr. Lee Cohen in the treatment of diseases affecting the ear, nose, and throat. Dr. Lumpkin became a leading specialist in the area and was assistant attending physician at MGH in the ENT department.

Mid-century

Maryland General Hospital prospered, and in 1940, great attention was given to improving the clinical training of residents and interns. The hospital gained a fully approved graduate surgical training program from the American College of Surgeons. Professional meetings and staff conferences were held, including weekly clinical-pathological, surgical, and medical round table discussions. Statistics for an average hospital day were:

- 223 inpatients;
- 10 accident patients;



Courtesy of Maryland General Hospital

- 2 births;
- 13 operations;
- 20 x-rays;
- 18 physical therapy sessions;
- 1,540 meals (using 624 eggs, 70 gallons of milk, and 16 quarts of cream);
- 2,425 pounds of laundry; and
- 610 gallons of fuel oil.



Courtesy of Maryland General Hospital

In 1946, the hospital bylaws were changed to allow non-Methodist individuals to be elected to the board of directors, and MGH became self-supporting through patient fees and public contributions. That year, the citizens of Baltimore gave one million dollars toward the construction of a new building that was to be the first in a three-phase construction program. The first new building was dedicated in 1956. Governor Theodore R. McKeldin officiated at the cornerstone laying ceremony. Mr. Robert Hicks, president of the board of managers; Rev. Dr. R.L. Wood, chairman of the Board of Hospitals and Home of the Methodist Church; and Mayor Thomas D'Alesandro, Jr., addressed the gathering. Replacing the original building constructed in 1883, the new structure housed an outpatient services department, radioisotope area, seven-room operating suite, and more than two hundred additional adult beds and forty bassinets.

Dedication ceremonies for the second phase of the rebuilding program were held November 18, 1962. Both Governor J. Millard Tawes and Baltimore Mayor J. Harold Grady were invited to attend. The last of the old buildings having been demolished, a new parking area was built, the hospital was expanded to 385 beds, and several new departments were added: a recovery room, intensive care unit, pathology department, outpatient emergency room, urological suite, and enlarged radiology department.



Courtesy of Maryland General Hospital

In 1965, another change occurred. Following much discussion and planning, MGH agreed to merge with one of the world's most modern facilities, the Baltimore Eye, Ear and Throat Charity Hospital, which had been in existence for 83 years. In 1966, the eye, ear and throat division wing of MGH was completed. The main entrance of the new wing on Linden Avenue provided access to the outpatient department, which is devoted primarily to eye-, nose-, and throat-related care. The wing also housed central service, pharmacy, coronary care, and six operating rooms devoted to ear, nose and throat surgery.



RICHMOND MARKET ARMORY.
5TH REGIMENT INFANTRY M.N.G.
FEBRUARY 1873. —— TO —— OCTOBER 1903.

Courtesy of Maryland General Hospital

In 1971, a 514-car, off-street parking garage completed the three-phase construction plan proposed in 1946. Connecting with the first floor of the main hospital, the six-deck garage straddles Linden Avenue and Madison Streets, offering easy accessibility for staff and visitors.

Recognizing the need for additional space to serve the growing outpatient population, hospital leaders looked north of MGH toward the old Richmond Market Armory. An open air market in the 1830s, the site was home to an impressive, multi-arched building that was completed in 1872. It was also known as the Aristocratic Market because it was patronized by wealthy families living in the nearby brownstone houses of Bolton Hill. From 1873 to 1903, the building served as an armory for the Maryland National Guard. When the Methodists assumed control of MGH in 1911, the market was used as an outdoor clinic. The building missed demolition twice. In the 1950s, a proposed expressway would have necessitated its removal, and in 1969, it was targeted to be replaced by a new fire department headquarters. In 1970, MGH arranged to purchase the armory building for outpatient services. To enlarge the hospital's area, the armory was renovated and a span was constructed across Armory Place to connect the two buildings. Today the armory houses the outpatient clinics and physician offices.

Looking to the future

In 1982, MGH appealed to the State Planning Commission to erect a new hospital in the Hunt Valley area of Baltimore County, but opposition by Baltimore City and existing county hospitals resulted in the courts blocking the attempt to relocate. In the mid-1980s, however, it did open two satellite centers in Catonsville and Timonium called Maryland General Health Care Center. Since then, MGH has renewed its commitment to the citizens of Baltimore City. In 1989, a four-story professional building and parking garage were constructed across from the hospital on Linden Avenue. In 1991, in conjunction with Bryn Mawr Rehabilitation Hospital, a noted facility in Malvern, Pennsylvania, MGH opened a rehabilitation center on the third floor. Most recently, the hospital received $30 million in triple A-rated bonds that will be used for various renovation and expansion projects beginning in the spring of 1995.

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Limiting restraint use for behavior control: the brain injury rehabilitation unit as a model

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ABSTRACT: *Physical or pharmacologic restraints are often used to control the behavior of patients who are agitated or who demonstrate behavior that is inappropriate or potentially dangerous. Centers that specialize in traumatic brain injury rehabilitation treat many patients who manifest agitated behavior. This article reviews behavior management within a brain injury rehabilitation setting and describes less restrictive restraint systems. A case study of the management of an agitated patient with traumatic brain injury is presented. Possible future trends in the use of restraint systems are discussed.*

Physical or pharmacologic methods are often used to restrain patients who display agitated, socially inappropriate, or potentially self-injurious behavior. Although multiple studies have noted the often limited documentation of reasons for applying restraints, the most commonly cited justification for restraint use is patient protection.[1] Other frequently listed reasons include prevention of falls, protection of medical devices and interventions (e.g., intravenous lines, Foley catheters, nasogastric or endotracheal tubes), control of wandering, and control of agitated behavior. Physical restraints include posey jackets, lap belts, strapped sheets, mittens, wrist and ankle ties, restraining beds and chairs, locked rooms, and to a lesser extent, locked wards. Pharmacologic restraints include drugs (e.g., neuroleptics, benzodiazepines) that modify behaviors considered inappropriate by medical protocol, but not perceived by the patient to require medicinal treatment.[1]

Available evidence suggests that restraints are overused in the United States. Use of physical restraint has been documented in 25% to 85% of patients in nursing homes and in 7.4% to 17% of patients on the medical

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Table 1. Rancho Los Amigos Levels of Cognitive Function Scale

I.	No response
II.	Generalized response to stimulation
III.	Localized response to stimuli
IV.	Confused and agitated behavior
V.	Confused with inappropriate behavior (nonagitated)
VI.	Confused but appropriate behavior
VII.	Automatic and appropriate behavior
VIII.	Purposeful and appropriate behavior

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floors of acute care hospitals.[2-4] In one study, physical restraints were used in 18.1% of patients who were out of bed on specialized dementia units and in 51.6% of patients on traditional nursing home units.[5] A study of restraints in an acute hospital setting found that use of multiple physical restraints was common; wrist restraints were applied most, followed by chest or jacket restraints.[6] In another study,[7] the chest restraint was most used on the acute service and lap belts were most used in the extended care wards. Observational studies indicate that restraints are used much less often in European countries without evidence of increased risk of injury.[8,9]

Although many studies have examined the use of restraints in psychiatric, acute, and long-term care environments, few authors have studied their use in rehabilitation settings.[10] A recent retrospective study at one rehabilitation center, however, found that 32.2% of patients were restrained at some time during hospitalization.[11]

Many patients who require rehabilitation have severe traumatic brain injury (TBI), most often from motor vehicle accidents, falls, or assaults. During emergence from coma, 11% to 30% of TBI patients may become agitated[12,13] and may require behavioral management intervention. The Rancho Los Amigos Scale of Level of Cognitive Functioning (RLAS) is commonly used to track recovery following TBI (see **Table 1**).[1] The most severe periods of agitation are RLAS Levels IV and V. Patients in Level IV are confused and agitated with a heightened state of activity or restlessness, have decreased capacity to process new information, and respond primarily to internal stimuli. Although behavior may be aggressive, it is reactionary and not rational. For patients in level V, agitation is generally reduced, but socially inappropriate behavior and confusion continue. Patients are highly distractible by external stimuli, have a nonselective attention pattern, and often become angry and frustrated when overstimulated.

Despite the challenge of managing the behaviors of TBI patients, brain injury rehabilitation units have policies that limit the use of restraints. The less restrictive devices and protocols that are used for behavioral management for individuals following TBI also may be useful in other medical settings.

Case study

A 30-year-old man suffered severe traumatic brain injury from an assault to the head with resultant loss of consciousness. At the acute care hospital, his initial Glasgow Coma Scale score was 11, but it quickly deteriorated to 7. Magnetic resonance imaging showed a right subdural hematoma. Intracranial pressure was monitored and controlled, but the patient required mechanical ventilation and tracheotomy and gastrostomy tube placement. There was slow neurologic recovery with a prolonged period of decorticate posturing.

The patient was transferred for acute inpatient brain injury rehabilitation on the 26th day after his injury. On presentation, he was purposefully responsive to painful stimuli, had spontaneous eye opening, and was able to track visually. He was unable to follow one-step commands, however, and was intermittently agitated. Vest restraint was used only at admission; the patient was placed in a mesh net bed the next day. Bilateral upper limb flexor spasticity placed him at low risk to remove medical interventions. The patient's awareness of his surroundings increased gradually, corresponding to increases in agitation and semi-purposeful behaviors. Nortriptyline was prescribed to help decrease agitation, and the patient was switched to a padded cubicle-type bed that decreased external stimulation but allowed increased freedom to explore the environment. Undesired behaviors were redirected by staff and acceptable responses were reinforced. When the patient was able to stand, he was returned to his original mesh net bed.

The patient became notably less agitated over the next two weeks. After being extubated, however, he became extremely verbose, emotionally labile, and impulsive, and had very poor social skills and judgment. Because of his impulsiveness and inability to manage sitting balance, a lap belt was used when he was in a wheelchair. On the 28th rehabilitation day, the patient's mini-mental status test score was 20 out of 30.

When the patient became ambulatory, he was allowed to wander within the confines of the locked unit and



Figure 1. Craig type containment bed

was encouraged to take responsibility for his own therapy schedule. His impulsivity decreased and his balance improved and he was allowed to use a regular hospital bed. Nortriptyline was discontinued successfully. The patient became more responsive to gestures and verbal cues and was able to modify his behavior appropriately. He was discharged in a much improved condition and was scheduled to continue therapy in an outpatient program.



Figure 2. Vail Optima 3000 Bed Enclosure.
Vail Products Inc. Toledo, Ohio.

Behavior management in brain injury rehabilitation

In rehabilitation units that treat TBI patients, the philosophy is to promote physical, cognitive, and functional independence in a supportive environment. Tailoring the environment to meet patients' individual needs is preferred to physical restraints. A team effort provides consistency and structure and reduces interstaff variability in response to patients.

Behavioral reinforcement. Specific behaviors are targeted for positive reinforcement and undesired behaviors are extinguished. A commonly used technique is to ignore a period of patient agitation and respond with increased personalized attention when the patient is calmer, thereby providing reinforcement for the desired behavior.

Reducing overstimulation. The effectiveness of behavioral reinforcement is enhanced by reducing sensory overstimulation. Agitated patients are treated in an environment that is quiet and free of excessive external stimuli, such as loud noises from television, radio, intercoms, bells, or alarms. Internal sources of patient discomfort also are recognized and treated (e.g., pain from past trauma, urinary and bowel dysfunction, agitation secondary to hypoxia or hyperthyroidism).

Cubicle beds. Specialized beds also reduce stimuli while providing a secure but less restrictive environment. The Craig bed, developed at Craig Hospital in Denver, Colorado, resembles a large playpen with a floor mattress enclosed by tall padded walls that effectively block outside stimuli. Large doors on one wall allow treatments within the bed space (see **Figure 1**). The Emory bed, developed at Emory University Hospital in Atlanta, Georgia, adds a raised frame to facilitate transfers and nursing care of the patient.[14] The Bryn Mawr bed, developed at Bryn Mawr Rehabilitation Hospital in Malvern, Pennsylvania, is designed with interlocking padded blocks that allow the bed's dimensions to be adjusted to suit individual patient needs. The Vail Optima 3000 bed system, developed in Toledo, Ohio, is a criblike mesh enclosure that securely fits around a standard hospital bed (see **Figure 2**). It allows the patient freedom of movement and the ability to observe the surrounding environment. Staff gain access through the sides of the enclosure, which open via large zippers.

Unit design. Cubicle beds lose their effectiveness when patients become ambulatory. Ambulatory patients on a brain-injury rehabilitation unit are given the freedom to roam in safe, unobstructed paths that promote exercise and discharge of restless energy. Exits can be disguised so as not to draw attention and focus for elopement; a closed-circle design, for example, allows patients to wander without having to be redirected at the end of a hallway. A locked unit with a coded numeric key pad or an alarm triggered by a wrist or ankle band worn by patients can be effective in keeping at-risk patients on the unit.

Pharmacologic intervention. Neuroleptic agents and benzodiazepines are largely discouraged for treating agitation in patients after brain injury. Neuroleptics have anticholinergic and dopamine blocking effects that may retard cognitive recovery, especially acquisition of new learning. Neuroleptics also may adversely affect neurophysiologic recovery.[15] Benzodiazepines are known to impair alertness, cognition, and memory, and can produce anterograde amnesia.[16,17] Growing evidence indicates that in patients with brain injuries, other medications (e.g., tricyclic antidepressants, stimulants, anticonvulsants, beta-blockers, lithium, buspirone) effectively decrease agitation and increase attention and the ability to learn new information.[18]

Discussion

The adverse effects of restraints are well documented. Use of pharmacologic restraint may result in confusion, falls, aspiration, and respiratory arrest. With physical restraint, the most serious complication is strangulation, most often associated with vest restraint.[10,19] Other reported complications include pressure-induced nerve injury, physical deconditioning, sensory deprivation, decreased muscle mass and strength, increased osteoporosis, pressure ulcers, abrasions, fecal and urinary incontinence, and nosocomial infection.[19] Physically restrained patients are more agitated[20] and may be at increased risk for falls from bed.[2,9] They may experience a loss of self esteem and autonomy, with associated effects of increased agitation, combativeness, fear, and humiliation.[2,19] Restraints may thus foster the very behavior that is to be extinguished.

The use of restraints has come under increased scrutiny, especially in nursing homes and extended care facilities. The Nursing Home Reform Act (October 1991) requires that long-term care facilities minimize the use of physical and pharmacologic restraints.[21] Guidelines call for restraints to be used only by physician's order for the physical safety of the individual resident or other residents. Duration and circumstances of restraint use must be identified. According to federal standards, patients in restraints must be checked every 30 minutes by appropriately trained staff who must keep an account of their surveillance.[22,23] Rehabilitation facilities also must restrict use of restraints to maintain compliance with accreditation standards established by the Commission on Accreditation of Rehabilitation Facilities.[24]

In a review of physical restraints, Marks[19] outlined evaluations and considerations that should occur before restraints are initiated. These include

- review of medications and discontinuation of agents with high likelihood of cognitive side effects;
- visual screening tests;
- muscular strength evaluation;
- evaluation for orthostasis;
- correction of environmental factors; and
- assessment of risk for falls.

In brain injury rehabilitation units, many of the above favorable conditions are present. Several factors distinguish brain injury rehabilitation units from other medical environments. Staff are specially trained to function as a team with shared goals that are clearly identified for the patient. Goals are functional in nature and stated so that progress can be objectively measured. Most patients are in a rapid phase of recovery and improvement is expected within a relatively short time.

An objective measurement of the level of a patient's agitation is useful in a brain injury rehabilitation setting. Two recognized objective tests are the Overt Aggression Scale (OAS)[1] and the Agitated Behavior Scale (ABS).[7] The OAS has 16 items that assess four categories: verbal aggression, physical aggression against objects, physical aggression against self, and physical aggression against others. The ABS grades 14 behaviors as absent, present to a slight degree, present to a moderate degree, or present to an extreme degree. Agitation scores on the ABS may range from 14 (agitation absent) to 56 (extremely agitated). Although these tools have been successful in measuring the presence and severity of agitation, they have not been used to determine the requirement for restraints. Research is needed to develop an objective assessment tool to determine if restraints are required, the relative risk of injury to the patient and others, and the degree of restrictive restraint that is necessary. The ideal test will be easy to administer; have good inter- and intra-tester reliability; be standardized across various medical settings with good reliability; be sensitive to high risk of injury; correlate with the level of restraint required; and predict when restraints can be discontinued or when a less restrictive device can be used.

Conclusion

Current research indicates that physical or pharmacologic restraints should be applied only when absolutely necessary. In the management of agitated patients, brain injury rehabilitation centers commonly use methods that promote functional and physical independence. Thus, they should serve as good models for managing problem behaviors. The development of an objective test to assess the need for restraint usage and to predict the level of restraint necessary could help clinicians make rational decisions in the prescription of restraint systems.

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Black American men have a 50% higher incidence of prostate cancer than age-matched white men and a 114% greater chance of dying from it. Although black men present at a younger age, they do so with a higher grade and stage disease. In addition to having a greater delay in diagnosis, they also have a poorer five-year survival rate than white men. A recently published analytical review, however, concluded that no consistent data have been presented to explain the etiology of these differences. Until futher data are available, increased efforts toward patient awareness and screening for prostate-specific antigen—which is now recommended with digital rectal examination for men older than 50 and younger men in high-risk groups—is warranted in the black community (*Urology* 1994;44:637-645).

Ocular syphilis and neurosyphilis in a patient with human immunodeficiency virus infection

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ABSTRACT: *A patient who presented with severely decreased bilateral vision was found to have syphilis and neurosyphilis that responded well to a 14-day course of penicillin and prednisone. The patient tested positive for HIV, which can alter the natural course of syphilis, often making the diagnosis and treatment difficult. Conventional therapy for syphilis may not be effective in patients with HIV. Any patient with syphilis who is in a high-risk group should be tested for HIV; conversely, any patient with HIV should be tested for syphilis if signs or suspicions exist.*

Acquired immune deficiency syndrome (AIDS) was first described in 1981 when the Centers for Disease Control (CDC) reported five cases of *Pneumocystis carinii* pneumonia in 26 cases of Kaposi's sarcoma in otherwise healthy young homosexual men.[1] AIDS has now reached staggering worldwide epidemic proportions. The latest report from the CDC estimates that more than one million people are infected with the human immunodeficiency virus (HIV). In 1991, 58,000 new cases of AIDS were reported in the United States, and it is estimated that between 1992 and 1994, the number of new cases increased by 60,000 to 70,000 annually.[2] The CDC recently expanded the 1987 AIDS surveillance case definition to include all HIV-infected people with CD4 counts less than 200 or a CD4 lymphocyte percentage less than 14. Also included are three more clinical conditions: pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer.[3] Although the number of new AIDS cases among homosexual and bisexual men and intravenous drug abusers appears to be reaching an annual plateau, the incidence by heterosexual transmission continues to increase.



Figure 1. Posterior pole of right eye. Note the diffuse chorioretinal lesions. Findings were similar in the left eye.



Figure 2. Peripheral retina of right eye. Chorioretinal lesions and vasculitis are evident.



Figure 3. Intravenous fluorescein angiogram of right eye. Diffuse retinal vascular leakage and hyperfluorescence of the optic nerve head can be seen. Also note the retinal pigment epithelial window defects corresponding to the chorioretinal lesions.

drug abusers appears to be reaching an annual plateau, the incidence by heterosexual transmission continues to increase.

Syphilis, a systemic sexually transmitted infection caused by the spirochete *Treponema pallidum*, increased in incidence throughout the 1980s. In fact, from 1986 to 1990, a new syphilis epidemic occurred in the United States. The number of diagnosed cases increased annually until 1990, when more than 50,000 cases of primary and secondary syphilis were reported,[4] the highest number of newly diagnosed cases of syphilis since 1948.

Recent reports in the literature theorize that concurrent HIV infection can alter the natural course of syphilis and may dictate a special category of treatment.[5-7] Numerous experts have noted a greater propensity for development of neuro-syphilis, quaternary syphilis, and treatment failure for secondary and neurosyphilis with concurrent HIV infection.[8-11]

Case presentation

A 28-year-old African male, a native of Malawi, presented to the Friedenwald Eye Institute at Maryland General Hospital with complaints of decreasing visual acuity over a one-week period. He noticed he had trouble seeing the blackboard during classes at his local community college. Visual acuity at presentation was 20/50 right eye and hand motions (HM) at two feet left eye. Examination at that time showed pupils that were equally round and reactive to light, but with a quick escape and fluctuation in size, indicating a possible bilateral afferent pupillary defect. Extraocular movements were full. Slit lamp examination showed 1+ anterior chamber cells and trace flare with 2+ vitreous cells bilaterally. Applanation pressures were 9 mm Hg bilaterally. Dilated fundus examination demonstrated multifocal chorioretinal cream-colored lesions throughout the retina bilaterally with evidence of vasculitis and retinal edema (**Figures 1 and 2**). Fluorescein angiography showed numerous retinal pigment epithelial window defects corresponding to the chorioretinal lesions, as well as hyperfluorescence of the optic nerves and diffuse retinal vascular leakage (**Figure 3**).

The patient denied any associated symptoms at that time. He reported no infections while in Africa other than a bout with malaria and no medical problems since his arrival in the United States three years earlier. He also denied any history of drug abuse or homosexual activity. He had no prior history of syphilis and had never been tested for HIV.

During the next two days, the patient's visual acuity decreased to count fingers (CF) at 1 foot right eye and HMs at 2 feet left eye. Blood tests showed a rapid plasma reagin (RPR) of 1:1024 and positive fluorescent treponemal antibody absorption (FTA-ABS). A further review of systems elicited a history of skin rash on the lower legs about three years earlier that resulted in a hyperpigmented, scarred area. Medical consultation was obtained. A lumbar puncture showed a glucose level of 57 mg/100 ml, a protein level of 75 mg/100 ml, 35 white blood cells/cubic mm with 87% lymphocytes, and a VDRL titer of 1:8. Computed tomography scan and magnetic resonance imaging of the brain were within normal limits. The patient was admitted to the hospital for treatment of ocular syphilis and neurosyphilis.

After 7 days of treatment with 18 million units of intravenous penicillin per day and oral prednisone 20 mg per day, the patient's visual acuity improved to 20/60 right eye and 20/50 left eye. Treatment was continued for 14 days and visual acuity improved to 20/25- bilaterally. Examination at discharge showed trace cell and flare of the anterior chamber with trace vitreous cells bilaterally. The chorioretinal lesions were smaller and more discrete and were showing signs of scarring with no further evidence of retinal edema (**Figure 4**). Fluorescein angiography continued to show some retinal vascular leakage, but to a much lesser degree (**Figure 5**). The patient was discharged from the hospital taking oral prednisone, which was to be tapered over a 10-day period. He continued to receive intramuscular benzathine penicillin 2.4 million units per week for three weeks after discharge.

The patient initially refused to be tested for HIV, but eventually consented on the last day of his hospital stay. He was evasive about any HIV risk factors other than his African background. He tested positive for HIV by the enzyme-linked immunosorbent assay (ELISA); the diagnosis was confirmed by Western blot analysis. His CD4 count was 237 cubic mm. His visual acuity after completion of penicillin therapy was 20/20 bilaterally, and examination showed brisk reactive pupils with no evidence of an afferent pupillary defect. To date the patient has had no further evidence of active uveitic disease. He has since begun zidovudine (AZT) therapy.



Figure 4. Posterior pole of right eye after treatment. The chorioretinal lesions are smaller and more discrete. Results were similar in the left eye.

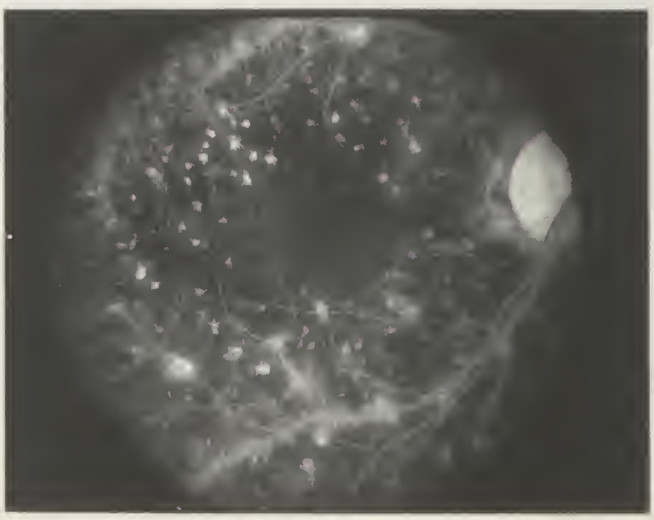


Figure 5. Intravenous fluorescein angiogram of right eye after treatment. Note the decreased leakage from the retinal vessels and optic nerve head as well as from the chorioretinal lesions.

Discussion

In an editorial in the *New England Journal of Medicine*, Dr. Edmund C. Tramont[12] quoted Sir William Osler's dictum, "Know syphilis in all its manifestations and relations, and all other things clinical will be added unto you." Dr. Tramont contemporized the quote by stating, "Know HIV infection in all its manifestations and relations, and all other things clinical will be added unto you."

Because syphilis and HIV have a common mode of transmission and epidemiologic disposition, it is not unusual for a patient presenting with any stage of syphilis also to be found to be HIV positive. A number of experts suggest that a specific relationship exists between HIV and neurosyphilis.[5,12-15] In one report, 1.5% of all patients with AIDS were found at some time during the course of the disease to have neurosyphilis, and 44% of persons with neurosyphilis had AIDS.[7] Concurrent HIV infection may alter the natural course of syphilis.[5-7,9,13-16]

Before the antibiotic era, neurosyphilis was seen in 6.5% of untreated, *T. pallidum*-infected individuals; since the introduction of penicillin, the incidence has decreased to less than 3%.[1] Since the AIDS epidemic, however, there have been reports of a greater frequency of developing neurosyphilis. Johns and colleagues[5] described four cases of neurosyphilis that presented over a period of 18 months. Two of the patients presented with meningiovascular syphilis, which usually occurs 5 to 12 years after the initial infection; in both patients it developed much earlier (4 months after the initial infection in one patient). The authors proposed that "a concurrent HIV infection can alter the natural course of syphilis by increasing the propensity of the disease to progress to neurosyphilis, decreasing the latency period before the onset of neurosyphilis, increasing the severity of the manifestations of neurosyphilis, or rendering standard therapy for primary and secondary syphilis inadequate." Other reports of cranial nerve dysfunction, cerebrovascular events, meningitis, and quaternary neurosyphilis (necrotizing encephalitis with meningiovascular syphilis) highlight the possibility of an increased risk of progression to aggressive forms of neurosyphilis in concurrent HIV infection.[8-10]

The pathogenesis for a relationship between the two diseases is thought to be a decrease in the immune response during an HIV infection.[12] The immune system uses both humoral- and cell-mediated defenses to fight treponemal infections. HIV infection affects the T4 lymphocytes needed for cell-mediated response, as well as the ability of T4 helper cells to assist B cell production of immunoglobulins against *T. pallidum*. On the other hand, the transient immunosuppression that occurs in the early stages of syphilis may alter the host response to HIV infection. Meningeal inflammation caused by either infection could facilitate the other organism's ability to penetrate the central nervous system.

Our patient claimed no history of, and there were no signs or symptoms to suggest, a past infection of syphilis other than scarring from a rash on the legs, which is of uncertain significance. The CDC, however, now recommends that all patients with syphilis be tested for HIV, especially if they have failed treatment for primary or secondary syphilis or have diagnosed neurosyphilis. It also has been suggested that HIV-positive patients who exhibit neurologic dysfunction be tested for syphilis.

Diagnostic serologic testing for syphilis includes nontreponemal-specific tests (VDRL, RPR), which can correlate with disease activity and are sometimes used to assess response to treatment, and treponemal-specific tests (FTA-ABS, *T. pallidum* hemagglutination assay), which are more sensitive tests and usually remain positive throughout one's life. Abnormal results of serologic testing for syphilis in concurrent HIV infection have been reported,[11] however, which may delay the appropriate diagnosis and treatment of a treponemal infection. If the diagnosis is questionable, biopsy of a lesion, darkfield examination, or direct fluorescent antibody staining techniques may be needed to make a definitive diagnosis. In addition, a positive RPR test may lead to a false positive ELISA HIV test.[16] The Western blot analysis has no cross reactivity and produces negative test results in seronegative patients. Cerebrospinal fluid (CSF) analysis also can be helpful in the diagnosis. A positive CSF titer on VDRL testing can be found during any stage of syphilis without neurologic symptoms. With concurrent HIV infection, a lumbar puncture is recommended before primary or secondary syphilis is treated.[5-9] If initial treatment fails, the CSF should be examined and followed after appropriate therapy. Serum tests alone cannot diagnose neurosyphilis. Although clinical manifestations may not be present, an abnormal CSF analysis demonstrating pleocytosis, elevated protein levels, or a positive VDRL is needed to diagnose neurosyphilis.

All patients with primary or secondary syphilis who have ocular or neurologic findings should be evaluated for neurosyphilis. If the patient does not improve following the initial treatment for primary or secondary syphilis (i.e., benzathine penicillin 2.4 million units IM), then the CSF should be evaluated and the appropriate treatment completed. Follow-up of patients with primary or secondary syphilis should include serologic testing at 1, 2, 3, 6, 9, and 12 months.[17] Retreatment is indicated if the nontreponemal test titer does not decrease four-fold.

The treatment for syphilis in a patient with HIV infection has been controversial. Our patient responded very well to a course of IV penicillin followed by weekly injections of IM benzathine penicillin for 3 weeks. This treatment is recommended for all patients with neurosyphilis. Our patient also was given oral prednisone to help treat the ocular inflammation. There have been reports of treatment failures with the standard IM benzathine penicillin therapy in patients with primary and secondary syphilis who either had, or were suspicious of having, HIV infection.[10,15] It is recommended that any patient with syphilis and concurrent HIV infection be treated using the regimen for neurosyphilis.[17] The recommended treatment is 12 to 24 million units of IV aqueous

crystalline penicillin G daily for 10 to 14 days. After therapy has been completed, the CSF must be examined every six months for 24 months. Retreatment should be considered if the cell count has not decreased at six months or the CSF is not entirely normal at two years.

Conclusion

Any patient with syphilis who is in a high-risk group should be tested for HIV and any patient with HIV should be tested for syphilis if signs or suspicions exist. In addition, any patient with concurrent syphilis and HIV infection should have a CSF analysis for neurosyphilis.

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Addendum

Since the submission of this article, two other patients who presented to our eye institute with similar ocular complaints were diagnosed with syphilis and neurosyphilis and tested positive for HIV. ■

Well Said!

"Absence of proof does not mean proof of absence" (Wells PS, Holbrook AM, Crowther NR, Kirsch J. Interactions of warfarin with drugs and food. Ann Intern Med *1994;121: 676-683).*

Brief report: chronic sinusitis management

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Reprints: *John F. Biedlingmaier, M.D., Assistant Professor/ Surgery, Director/Head & Neck Services, Maryland General Hospital, 827 Linden Avenue, Baltimore, MD 21201*

Sinusitis is not a disease unique to modern man. For nasal congestion, the ancient Egyptians snorted a powder made from dried cabbage leaves. Even the Talmud describes a nasal ointment made from myrrh and the dung of a white dog. Chronic sinusitis is the most common chronic illness in the United States, outnumbering hypertension and diabetes. It affects more than 35 million Americans per year and is estimated to account for more than $2 billion per year spent on medical and surgical treatment.[1] This article briefly reviews the diagnosis and medical management of chronic sinusitis and discusses a new management technique, endoscopic sinus surgery.

Diagnosis

Although the symptoms of chronic sinusitis are many and varied, facial pain is the most common. Deep pressure and pain behind or above the eye generally indicate ethmoid disease, whereas cheek or upper dental pain is typical of patients with maxillary sinusitis. Alcohol (especially beer and red wine), changes in barometric pressure (rainy days) and exposure to pollutants (e.g., cigarette smoke) often precipitate acute attacks of facial pain and nasal congestion.

The clinical examination shows swollen, beefy red nasal membranes that shrink poorly with topical decongestants. Facial erythema, edema, or temperature elevation is rarely associated with chronic sinusitis and should alert the treating physician that a complication such as facial or orbital cellulitis is present.

Medical management

Antibiotics for chronic sinusitis should be directed toward the usual organisms seen in acute sinusitis (e.g., *Staphylococcus*, *Streptococcus*, and *Haemophilus influenzae*). Because anaerobic and beta-lactamase-producing organisms also may be present, the augmented penicillins

Table 1. Sinus surgery performed in 98 patients at Maryland General Sinus Center

	Unilateral	Bilateral	Total
♦ Anterior ethmoidectomy	22	42	106
♦ Posterior ethmoidectomy	1	4	9
♦ Sphenoidectomy	2	-	2
♦ Partial mid turbinectomy	22	42	106
♦ Maxillary sinus antrostomy	22	42	106
♦ Maxillary sinus polypectomy	8	-	8
♦ Septoplasty	-	-	8
♦ Submucosal resection of inferior turbinates	16	-	16

Total intranasal procedures = 361
Total endoscopic procedures = 337

(Augmentin, UNASYN) should be considered and may be taken for two to four weeks.[2] Systemic decongestants that contain mucolytic agents are ideal because they shrink nasal mucosa while promoting drainage. Combinations such as pseudoephedrine and guaifenesin (Guaifed) and phenylpropanolamine and guaifenesin (Entex) are effective and widely prescribed, but should be used cautiously in patients with labile hypertension. The topical cortisone nasal sprays work well to reduce mucosal edema and inflammation. Their systemic absorption is quite low and they may be used for extended periods without risking adrenal suppression. Antihistamines should be used only for patients whose chronic symptoms are secondary to nasal allergy. The long-acting, nonsedating antihistamines (Seldane, Hismanal) may thicken nasal secretions and inhibit mucocilliary clearance, thus aggravating symptoms in patients with nonallergic rhinitis. This class of antihistamines should be prescribed cautiously because cardiac and hepatic side effects have been reported, especially in patients on antifungal therapy or when combined with macrolide antibiotics (e.g., erythromycin).

Table 2. Analysis of results in 64 patients

♦ No further symptoms	41/64	64%
♦ Greatly improved (<2)	12/62	18.7%
♦ Improved (>2, <5)	8/64	12.5%
♦ No change	3/63	4.8%
♦ Worse	0/64	0%
Overall success		**95.2%**

Patients with recurrent or nonresolving symptoms should be evaluated by a sinus computed tomography (CT) scan without contrast dye. Compared to conventional x-ray or magnetic resonance imaging, the CT scan is far superior for detecting sinus mucosal disease or bony malformations.

Functional endoscopic sinus surgery

Until Dr. David Kennedy introduced the European method of functional endoscopic sinus surgery (FESS) to the American literature in 1985,[3] American otolaryngologists used surgical techniques described at the turn of the century. The Caldwell Luc maxillary sinus operation was first described in 1894 and ethmoid surgery and the nasal antrostomy were first described in 1920 by Moser. All of these procedures were designed to eradicate mucosal disease.

FESS is based on the principle of returning the sinus cavities to their normal function. Using 4 mm x 12" telescopes and specially designed instruments, the surgeon unroofs the small multiple cells of the ethmoid sinuses. The natural osteum of the maxillary sinus is also identified and enlarged, thus promoting mucocilliary clearance. FESS is an outpatient procedure that requires little or no packing and patients often return to work in seven days. Data from more than 300 procedures performed in 98 patients treated at the Maryland General Sinus Center indicate that overall success is quite good (see **Table 1** and **Table 2**).[4] There were no major orbital or central nervous system complications among this group of patients. Other studies indicate the procedure is successful in 88% to 96% of patients.[5,6]

Conclusion

Medical treatment is recommended for all patients suffering from chronic sinus disease. If symptoms return frequently or persist despite medical therapy, a noncontrast CT scan is indicated. If sinus pathology is detected, patients may benefit from the new endoscopic sinus techniques. In experienced hands, the high success rate and low complication rate make endoscopic sinus surgery an exciting new method for treating chronic sinus pathology.

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The sources of salicylic acid, the most-used drug in the world, are numerous, and it has been known for centuries that the bark, fruit, and leaves of certain plants have healing properties. Plant extracts were used to obtain salicin, a glucoside of salicylic acid, the active compound. Biblical references to the balm may be found in Genesis, Jeremiah, and Ezekiel. The Greeks proclaimed its analgesic effects and many North American Indian tribes used the juice of the willow bark to reduce fever.

Although salicylic acid was a model for ablating pain and reducing fever, it too often produced nausea and vomiting. A century ago, Dreser[1] conducted laboratory investigations that produced three effective compounds: the sodium, phenyl, and acetyl derivatives. Of these, the acetyl compound seemed most promising. Dreser realized, however, that its long chemical name, *acetyl salicylate,* would be difficult for the public to understand and use. He therefore created an acronym. Using the old name for salicylic acid (*spirsäure*) and the letter *a* from the word *acetyl*, he coined what is now a household word: *aspirin.*

JOSEPH M. MILLER, M.D.

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American physicians are not alone in complaining about the vagaries of legal proceedings. In a letter to the editor of the *London Times* (December 26, 1994), C.B.T. Adams, a neurosurgeon, described his recent experience as an expert witness. Although the incident had happened in 1987, the hearing at which he was to testify was not scheduled until 1994. Asked to reserve two days for testimony, Dr. Adams rescheduled all his appointments (more than 40 patients) for the specified dates, only to be told each previous evening that his appearance for the next day was cancelled. When he finally insisted on giving his evidence, "the solicitors and barristers were quite surprised to hear of the effects their delays were having on patients." Concluding that "the only people who will be prepared to act as experts will be retired professionals," Dr. Adams states: "If I managed my professional activities (especially my operating lists) as chaotically as the legal profession, I would be hauled in front of the General Medical Council."

Researchers at Bowman Gray School of Medicine in Winston-Salem, North Carolina, are using computer software and a computer mouse to turn spiral computed tomography images of a patient's colon and airways into three-dimensional simulations of colonoscopy and bronchoscopy. Although these medical applications of virtual reality are not expected to replace the conventional procedures, preliminary studies indicate they may be a valuable means of detecting abnormalities that require further investigation. Like other high-tech procedures, however, equipment costs are high: spiral CT scanners cost more than $1 million, and the virtual reality computer used at Bowman Gray is about $120,000 (*Health Technology Trends* 1995;7(1):3).

Pertinent medical intelligence: accidental digital injection of epinephrine

Frank R. Claudy, M.D.

Dr. Claudy is chief of the department of family practice at Maryland General Hospital in Baltimore.

Case history

A 37-year-old man with a history of severe asthma and multiple food allergies, including anaphylactic reaction to peanuts, developed acute dyspnea following breakfast at home. Although unsure of the cause, he attempted to use an epinephrine self-injector on his thigh, but instead injected the base of his right index finger with most of the 0.3 cc contained in the device. The finger immediately blanched and became cold. The patient's respiratory symptoms abated completely within a few minutes and he went to work, hoping that the finger's color and temperature would soon return to normal. Six hours after the accidental injection, however, the finger was unimproved, and the patient presented to the office for evaluation.

Examination showed slight ecchymosis at the injection site, which was located in the center of the metacarpophalangeal flexor crease. The finger was not swollen, but was whiter and cooler than the other digits. Nailbed capillary refill was only slightly attenuated. Motor function was intact, but the finger was markedly and diffusely hypesthetic to light touch.

Initial management in the office consisted of topical application of nitropaste with an occlusive cover of plastic wrap. Fifteen minutes later, the finger had regained some of its color and was appreciably warmer. The patient was then seen by a hand surgeon, who documented adequate bilateral digital arterial pulses by Doppler ultrasonography. The patient was allowed to return home with a plan of close follow-up.

Twelve hours after the injury, the patient reported rapid onset of tingling discomfort in the involved finger, accompanied by skin blushing and palpable warmth. Follow-up examination several days later showed minimal epithelial peeling and mild hypesthesia to light touch. One month following the injury, the finger was completely normal.

Discussion

Although uncommon, accidental digital injection of epinephrine via self-injector has been previously reported in the literature.[1-3] Anxiety, compounded by unfamiliarity with the autoinjector, can result in the patient's inadvertently holding the device upside down during attempted self-administration, with consequent digital injury. The patient described above had been trained as a child to inject himself with a conventional preloaded syringe, but did not receive subsequent instruction in the proper use of the autoinjector.

Epinephrine causes marked reduction in cutaneous blood flow, with constriction of smaller arterioles, precapillary sphincters, and subcapillary venules. Digital arterial vasospasm secondary to epinephrine can be prolonged; if untreated, severe skin slough and frank tissue necrosis may occur.[4]

Evaluation of the involved digit should include inspection of the nailbed for presence of capillary refill and Doppler evaluation of the digital arteries. Treatment options include digital injection of the alpha-blocker phentolamine (by local infiltration or intra-arterially) and emergency local sympathectomy.

Topical application of nitrates has been discussed in the literature, but we were unable to locate a previous report of its successful use in an injured patient. It is certainly the least invasive treatment and is readily available in the office. (If prepared nitropaste is not at hand, a facsimile may be prepared by grinding several sublingual nitrate tablets and mixing them with a dab of water-based vehicle, such as a mild steroid cream.)

Aftercongestion normally occurs during the recovery period, probably caused by changes in vascular reactivity secondary to tissue hypoxia.[4] It is helpful to explain to the patient that this phase may be accompanied by tingling and discomfort.

Epinephrine also may be self administered by inhalation. In one study, 20 puffs of a metered-dose aerosol (equal to 0.3 mg) were found to be more reliable in delivering rapid therapeutic plasma epinephrine levels than 0.5 mg given subcutaneously.[5] The authors posited that the high airway concentrations of epinephrine achieved by inhalation may be advantageous for preventing the development of anaphylactic bronchospasm. A more recent study[6] confirmed that epinephrine is absorbed faster and more reliably by inhalation than by subcutaneous injection, but also noted that inhalation-achieved plasma levels fell more rapidly than those achieved subcutaneously. The authors suggest that patients who use epinephrine metered-dose inhalers for anaphylaxis prevention be instructed in the likely need for repeat administration. On balance, it would appear that inhalation of epinephrine may be an effective, simple, and less hazardous method for patients to use for protection from anaphylaxis.

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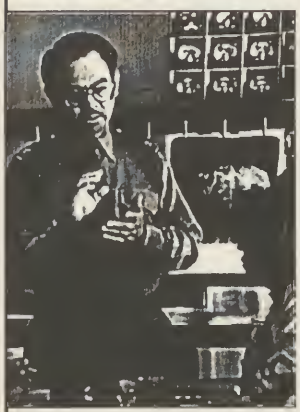
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Psychotic symptoms in the elderly may be iatrogenic. Drugs that can evoke psychotic symptoms in elderly patients include

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- benzodiazepines
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- analgesics and anti-inflammatory drugs
- antineoplastic drugs
- anticonvulsants
- prednisone
- antiarrhythmics and cardiac drugs

Grossberg GT, Manepalli J. The older patient with psychotic symptoms. *Psychiatric Services* 1995;46:55-59.

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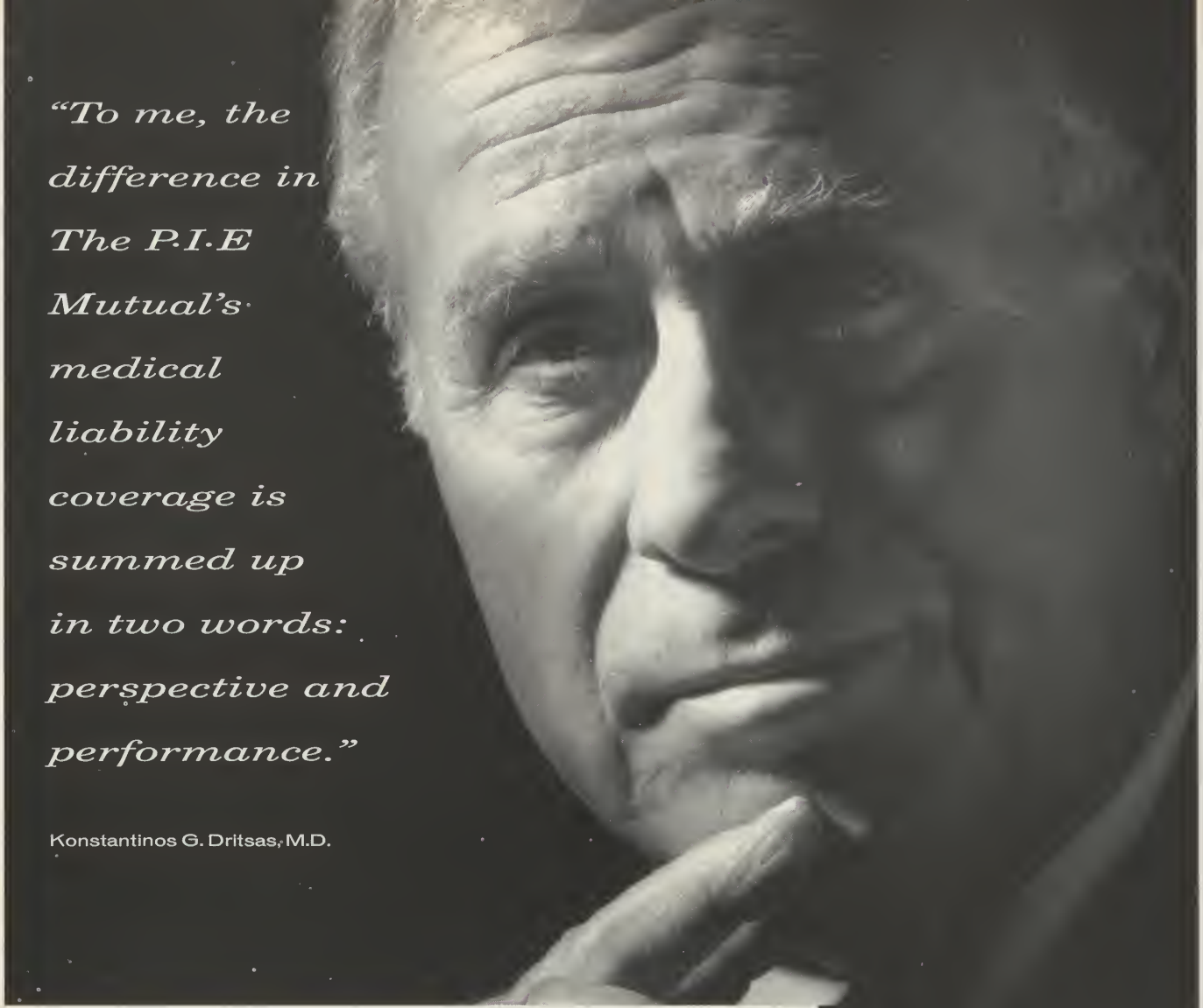
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Book Reviews

Foundations of Epidemiology (Third Edition). David E. Lilienfeld, M.D., MSEngin., M.P.H., F.A.C.E., and Paul D. Stolley, M.D., M.P.H., F.A.C.E. New York, NY: Oxford University Press; 1994. 371 pages. $49.95 (hardcover); $27.50 (paper).

Understanding basic epidemiology is essential for physicians who wish to do better than what Osler referred to as "penny in the slot" medicine. The textbook by Lilienfeld and Stolley is one way to learn, or re-learn, the basic concepts of epidemiology. Dr. Lilienfeld is a senior epidemiologist at the EMMES Corporation and a co-founder of the International Society for Pharmacoepidemiology and the International Society for Environmental Epidemiology. Dr. Stolley is professor and chairperson of the department of epidemiology and preventive medicine at the University of Maryland. In the authors' words, "The book has been designed as a text for introductory courses in epidemiology, in schools of medicine, public health, allied health sciences, dentistry, nursing and veterinary medicine . . . ."

A new chapter in this revised edition, "Epidemiology in Clinical Practice," should be of particular interest to practitioners. Although last in the book, it should be the first to be read by clinicians, as an introduction to why they should delve into some of the more technical chapters.

The chapter entitled "An Overview of the History of Epidemiology" is short, entertaining, and enlightening. It refers to several interesting articles by David Lilienfeld and his father, Abraham Lilienfeld, Sr., author of the first edition of the book.

The chapters on mortality and morbidity statistics and studies are clearly written and should be of interest to practicing physicians. In the mortality studies there is a fascinating description of Dr. Paul Stolley's work in showing excess deaths from isoprenaline in asthma aerosol inhalers (one of the many examples of the importance of epidemiology for clinical practice). The clearly written and important sections on cohort studies and clinical trials should be of interest to practicing physicians as well as students of epidemiology.

There are two omissions of which the reader should be aware. First, there is no mention of potentially productive years of life lost (PPYLL), years of potential life lost (YPLL),[1] or disability or adjusted life years (DALYS),[2] which are vital in examining the impact of disease on society. Second, I could find no mention of injuries! Only slightly more than one page refers to the outmoded term *accidental deaths*. Readers of the book should know that injuries are the major cause of productive years of life lost in the United States, Europe, and essentially all countries in the western hemisphere.[3] The authors should find space in the next revision for these two important subjects.

This book is strongly recommended to anyone interested in learning the basic concepts of epidemiology, or re-learning them to apply to clinical practice.

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Tales in Pursuit of Quality in Health Care. Frederick M. Gales, M.D., editor. Tampa, FL: American College of Physician Executives; 1994. 114 pages. $20 ACPE member; $25 nonmember (paper).

This book is a compilation of 59 cases presented by different clinicians, administrators, nurses, and pharmacists. The editor is a medical director and partner in a health care research and strategic consulting group in Boston. The primary emphasis of this work concerns the mistakes that have crept into the system in the delivery of patient care. It presents the manner in which, once recognized, these problems can be eliminated, resulting in the improvement of quality, efficiency, and/or cost of care.

The book can be read from beginning to end for its pure enjoyment and instruction, or it can be used as a reference because the editor has provided two indexes—one he calls "Theme Index" and the other, "Directory of Practice Settings." Under the theme index he subdivides the cases into case types, problems, solutions, and benefits, with numerous subdivisions in each category. In each of the subdivisions, he refers the reader to specific examples by case number. He likewise indexes the directory of practice settings into subgroups and again provides typical incidents that exemplify them.

This brief manual should be read by all who actively provide patient care, regardless of where they fit into the system. It should especially be used by teachers of students and residents because it provides typical examples of problems that providers encounter in the real world of medicine. It offers the opportunity to learn from the error of others rather than waiting to obtain this knowledge through our own mistakes.

MARION FRIEDMAN, M.D., F.A.A.F.P.
Baltimore, Maryland

■ ■ ■

The PDR Family Guide to Prescription Drugs (Second Edition). Medical Economics Data. Montvale, NJ: Medical Economics Data; 1994. 958 pages. $24.95 (paper).

The PDR Family Guide to Prescription Drugs is ostensibly designed to guide the layperson through the often confusing world of modern pharmacotherapy. That it requires 958 pages to do so is not surprising, since it is a comprehensive compendium. What is surprising to this reviewer is the way the volume accomplishes its purpose with simplicity, clarity, and style. Printed on sturdy stock that should withstand a good deal of use, the book is written at approximately an eighth-grade reading level, making the contents accessible to a large segment of the population.

The organization and layout are excellent. The opening section is a full-color drug identification guide, similar in appearance to that contained in the *Physicians' Desk Reference*, except that the drugs are arranged alphabetically by generic name. The main section, called "Drug Profiles," gives a detailed discussion of each prescription drug, including indications, mechanism of action, contraindications, side effects, warnings, food and drug interactions, dosage, and important special facts. The subheadings are visually very easy to find, and the drugs are listed alphabetically by generic and brand names. The list is current and complete. The third section of the book is a collection of very readable and interesting essays on major disease states and their current management. At the back of the book is a unique assortment of appendixes covering such subjects as alcohol and sugar-free products, poison control centers, and drugs that may cause photosensitivity.

Overall, the book is accurate, informative, and conservatively written. The editors have obviously attempted to enhance rather than weaken the physician-patient relationship. The book is both user friendly and doctor friendly, and this family physician will certainly recommend it to his patients from now on. It ought to remove much of the unnecessary "mystery" that surrounds the subject of prescription drugs.

BRAD J. COOPER, M.D., F.A.A.F.P.
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To Our Readers

The Editorial Board of the *Maryland Medical Journal* invites you to submit reviews of books, videos, and films of interest to the medical profession. Bringing your evaluation and analysis to the attention of your colleagues will be informative and stimulating. Send your report to: Chris Papadopoulos, M.D., Book Review Editor, *Maryland Medical Journal*, 1211 Cathedral Street, Baltimore, Maryland 21201.

In Memoriam

Edward D. DeLamater, M.D., former staff physician at the Eastern Shore Hospital Center in Cambridge, Maryland, died November 24, 1994, at his home in Oxford, Maryland. Dr. DeLamater attended Montclair Academy and the Conservatory of Art and Music at Oberlin College, where he studied opera. Later at Johns Hopkins University, he earned a master's degree in botany, and from Columbia University he received a Ph.D. in bacteriology and his medical degree. During World War II, Dr. DeLamater served as officer in charge of the Rheumatic Fever Control Program for the U.S. Army Air Force, following which he was named a fellow in dermatology at the Mayo Clinic in Rochester, Minnesota. In 1947, he became an assistant professor in bacteriology and mycology until he moved to the University of Pennsylvania, where he worked as a research professor of dermatology and microbiology. From 1963 until 1966, Dr. DeLamater was chairperson of the department of microbiology at New York Medical College. He then took a position at Florida Atlantic University, where he was later appointed a Distinguished University Professor of Science. He came to the Eastern Shore Hospital Center in 1978, where he worked until 1982. Former president of the New York Medical Research Society, Dr. DeLamater was a member of many medical and professional societies and had published more than 140 scientific articles. He was a fellow of the Royal Society of Health and the American Geriatrics Society, and a former member of the board of directors at the Metropolitan Hospital in New York. Dr. DeLamater was 82.

Leo I. Donovan, M.D., a family physician in the Bethesda and Washington areas for 50 years, died of congestive heart failure at his home in Bethesda on January 29, 1995. Originally from Washington, DC, Dr. Donovan received his medical degree from Georgetown University School of Medicine. He served his internship at Georgetown University Hospital, where, in 1934, he was awarded a fellowship in internal medicine. From 1935 until 1936, Dr. Donovan was an instructor in anatomy at Georgetown. For the next two decades, Dr. Donovan served on the medical board of the Selective Service System, ruling on appeals for medical deferments from the draft. He maintained a general medical practice in Prince George's County until his retirement in the mid-1980s. A former president of the Bethesda Kiwanis Club, Dr. Donovan was a member of several civic and professional organizations. He was 85.

Harold V. Harbold, M.D., a founding member of the Maryland Academy of General Practice, died at his son's home in Jarrettsville on December 3, 1994. Born in York County, Pennsylvania, Dr. Harbold received his medical degree from Temple University, where he was awarded the W. Wayne Babcock Medal in recognition of his surgical skills. He served internships at York Hospital and was a first lieutenant in the Army assigned to Civil Defense in Baltimore City during World War II. In addition to his private practice, which spanned more than 40 years, Dr. Harbold was a doctor for five public schools, the city health department, the draft board, and many convalescent homes. He was on the staffs of Saint Joseph and Maryland General hospitals and helped to form the National Academy of General Practice of Medicine in Cincinnati. A 50-year member of Med Chi, Dr. Harbold was a member of several professional societies. He was 81.

Lawrence W. Malin, M.D., a co-founder of Prince George's County's first hospital and a general practitioner in Adelphi, Maryland, died at Washington Adventist Hospital on February 5, 1995. Born in Vassar, Michigan, Dr. Malin received his medical degree in 1938 from the former College of Medical Evangelists, now Loma Linda University in Loma Linda, California. Following his graduation, he moved to Riverdale, where he joined his brother in private practice. Together they established the nonprofit Medical Group Foundation and in 1942, opened the 58-bed Eugene Leland Memorial Hospital, which grew to 120 beds before its closing in 1993. In addition to his private practice, Dr. Malin served as the hospital administrator until 1965. Dr. Malin and the Medical Group Foundation established the Wytheville Memorial and Tidewater Memorial hospitals in Virginia, financed a project that provided free medical treatment to natives living along the Amazon River, and assisted many medical students through school. Dr. Malin was involved with many professional and community organizations, including the establishment of the Beltsville Seventh-Day Adventist Church. He was 81.

William G. Marr, M.D., a retired ophthalmologist, died February 10, 1995, at his Greenspring Valley home, of complications from Parkinson's disease. Dr. Marr received his medical degree from The Johns Hopkins University School of Medicine in 1942 and served an internship at the Wilmer Eye Institute. He joined the army In 1944, served as a battalion surgeon, and was

discharged in 1945 with the rank of captain. Dr. Marr returned to the Wilmer Institute and completed his residency in 1948. In addition to his private practice of more than 30 years, Dr. Marr was an assistant professor of ophthalmology at Wilmer and was on the staffs of the Johns Hopkins Hospital, Greater Baltimore Medical Center, and Saint Joseph Medical Center. He was 78.

Irving Scherlis, M.D., chief of urology at Harbor Hospital Center for 29 years until his retirement, died there of lung cancer on February 9, 1995. Dr. Scherlis earned his bachelor's degree in 1940 from The Johns Hopkins University and his medical degree from the University of Maryland School of Medicine in 1943. He was an army surgeon from 1945 to 1947, and was discharged with the rank of major. Following his military service, Dr. Scherlis completed his internship at Sinai Hospital, and in 1950, completed his residency in urology at Sinai as well. In addition to his years at Harbor Hospital Center, Dr. Scherlis was senior attending physician at Sinai Hospital. A 40-year member of Med Chi, Dr. Scherlis was a member of several professional organizations and was also an amateur radio operator. He was 75.

John R. Smith Jr., M.D., serving his eighth term as president of Queen Anne's County Medical Society, died February 2, 1995, of a heart attack. Originally from Church Hill, Maryland, Dr. Smith graduated from the University of Maryland School of Medicine and completed his internship and one year of residency at the former Hospital for Women of Maryland. He served another year of residency at Union Memorial Hospital in Baltimore and a fellowship in internal medicine at Hopkins. In 1951, he entered the U.S. Air Force, serving as chief of medicine at Mitchell Air Force Base in New York. From 1954 until 1960, Dr. Smith maintained a private practice in New York City. He was an instructor in medicine at Cornell medical school and an attending physician for the medical school at New York Hospital. He returned to the Eastern Shore of Maryland in 1960, practicing internal medicine in Centreville until his death. Dr. Smith served on various boards, including the Delmarva Foundation for Medical Care, Inc., and Farmers National Bank of Centreville. He was 71.

James E. Stewart, M.D., a founding partner of Radiology Diagnostic Centers, died at his home in Potomac, Maryland, on December 9, 1994. Dr. Stewart, a graduate of Rockhurst College in Kansas City, Missouri, received his medical degree from Marquette University School of Medicine in Milwaukee, Wisconsin. From 1961 until 1972, he was a flight surgeon for the U.S. Air Force and served in Vietnam. He then moved to Rockville, Maryland, where he established his medical practice. A former president of the Gaithersburg Model Railroad Society, Dr. Stewart was an active member of the Maryland Midland Railroad. He was 60.

Jonathan M. Sutton, M.D., an Annapolis pediatrician, died of cancer at his home on January 1, 1995. Originally from Richmond, Dr. Sutton graduated from the University of Virginia in 1957, and in 1961, from the Medical College of Virginia. He completed his pediatric internship and residency at Baltimore City Hospital. For two years, Dr. Sutton served as chief of pediatrics at the Dover Air Force Base hospital in Delaware. From 1966 to 1994, he practiced in Annapolis. Dr. Sutton was founder and medical director of Pathways, an adolescent and young adult substance abuse treatment center in Annapolis, and was past president of the Live Free Council, Inc., an adolescent drug and alcohol abuse prevention program. A diplomate of the American Board of Pediatrics, Dr. Sutton was a member of many professional organizations and was recently voted into "Who's Who in America." Dr. Sutton was 59.

No additional information was available at press time for the following members:

Ruth Baldwin, M.D.
Baltimore City

Donald F. Bartley, M.D.
Dorchester County

Ronald B. Landman, M.D.
Prince George's County ..... December 11, 1994

Howard B. Mays, M.D.
Baltimore City ..... July 12, 1994

Glen Pincock, M.D.
Montgomery County ..... December 16, 1994

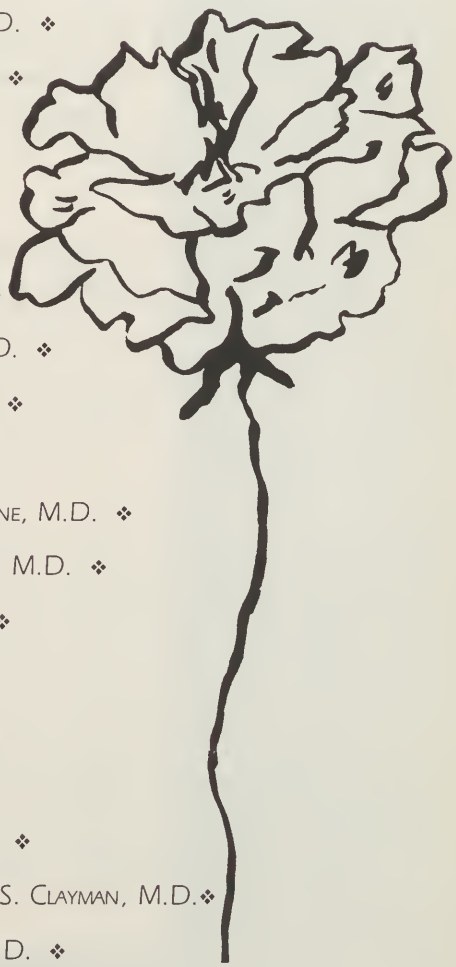
Daniel Wilfson, M.D.
Baltimore City ..... October 9, 1993

Alliance

Doctors' Day, March 30, 1995

As we commemorate Doctors' Day 1995, members of the Alliance to the Medical and Chirurgical Faculty of Maryland and its component alliances offer special recognition to the following physicians for their dedication and service to medicine.

Gino F. Zarbin, M.D. ❖ William A. Dombrowski, M.D. ❖ Anthony M. Dombrowski, M.D. ❖ Marco A. Zarbin, M.D. ❖ Sergio C. Zarbin, M.D. ❖ S.G. Sullivan, M.D. ❖ Umberto Villa Santa, M.D. ❖ Maria Grazia Ascoli, M.D. ❖ Nino Ascoli, M.D. ❖ Allan D. Jensen, M.D. ❖ Allan Silver, M.D. ❖ William F. Dombrowski, D.D.S. ❖ H. Leonard Warres, M.D. ❖ Stephen E. Warres, M.D. ❖ Neil E. Warres, M.D. ❖ Herbert J. Levickas, M.D. ❖ Augusto F. Figueroa, Jr., M.D. ❖ Steven J. Brand, M.D. ❖ John L. LeRoy, Jr., M.D. ❖ Charles E. Taylor, M.D. ❖ Carl Segal, M.D. ❖ Toshi Tsurumaki, M.D. ❖ Henry S. Gering, M.D. ❖ George E. Linhardt, Jr., M.D. ❖ John M. Dennis, M.D. ❖ Leslie R. Miles, Jr., M.D. ❖ Francis C. Mayle, Jr., M.D. ❖ DeWitt E. DeLawter, M.D. ❖ R. Kennedy Skipton, M.D. ❖ Robert C. Thompson, M.D. ❖ James M. Bisanar, M.D. ❖ Donald H. Dembo, M.D. ❖ Alfred A. Leszcsynski, M.D. ❖ Angela Peterman, M.D. ❖ Jose M. Yosuico, M.D. ❖ John B. DeHoff, M.D. ❖ Margaret Snow, M.D. ❖ William J. Reardon, M.D. ❖ Leopoldo Salazar, M.D. ❖ Thomas F. Herbert, M.D. ❖ Sergio Alvarez-Velasco, M.D. ❖ Renaldo Lee-Llacer, M.D. ❖ Juliana Del Rosario, M.D. ❖ Maria L. Del Rosario, M.D.❖ Joseph Snyder, M.D. ❖ George M. Boyer, M.D. ❖ Lorin F. Busselberg, M.D. ❖ Robert R.R. Roberts, M.D. ❖ Stuart J. Goodman, M.D. ❖ Peter C. Lizas, M.D. ❖ Vincent M. Osteria, M.D. ❖ Alberto S. Barretto, M.D. ❖ Lettie Galvez, M.D. ❖ Leo Bellantoni, M.D. ❖ John Ballantoni, M.D. ❖ Ben Bernstein, M.D. ❖ Basem Azar, M.D. ❖ Brian Yeo, M.D. ❖ Jeff Ashley, M.D. ❖ George H. Bone, M.D. ❖ Vicente R. Carag, Jr., M.D. ❖ David S. Clayman, M.D. ❖ Jacoues A. Zephirin, M.D. ❖ Vickie Casibang, M.D. ❖ Vincent Casibang, M.D. ❖ Raymond Wilson, M.D. ❖ Richard Hirata, M.D. ❖ Samuel Nava, M.D. ❖ Raul Felipa, M.D. ❖ Ronald Kho, M.D. ❖ Renato Lapidario, M.D. ❖ George H. Wathen, M.D. ❖



In Memoriam ❖ M. McKendree Boyer, M.D. ❖ Elmer G. Linhardt, M.D. ❖ John T. Lynn, M.D. ❖ John R. Smith, Jr., M.D. ❖ Robert S. Hotchkiss, M.D. ❖ John G. Ball, M.D. ❖ Louis S. Welty, M.D. ❖ Frank C. Marino, M.D. ❖ David S. Clayman, M.D.❖ Joseph R. Liberto, M.D. ❖ Irvin P. Klemkowski, M.D. ❖ Pirso E. Joson, Jr., M.D. ❖ John H. Hirschfeld, M.D. ❖ Wallace S. Sadowsky, M.D. ❖ Edward L.J. Molz, M.D. ❖ Ralph Reiter, M.D. ❖

Contributions to the American Medical Association Education and Research Foundation (AMA-ERF) have been made by the spouses, parents, and friends of the named physicians.

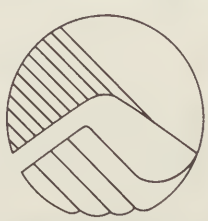
COMING OUT OF THE DARK

Med Chi's Physician Rehabilitation Committee deals with the substance abuse and mental health problems of Maryland physicians, with a confidential and nondisciplinary focus...Addiction, Marital/Family Conflicts, Psychiatric Illness, Organic Impairment, Physical Handicap...If these problems exist, we can help find the solution. Call us.

The Physician Rehabilitation Committee of Med Chi is available to all Maryland physicians, and their families. The Committee is NONDISCIPLINARY and information is kept CONFIDENTIAL. If you, a colleague, or family member is in need of our services call (410)962-5580 or call toll free (800)992-7010, or leave a message 24 hours a day, 7 days a week at (410)727-1020.

HELPING IS OUR BUSINESS...All donations to the Physician Rehabilitation Committee are used for the delivery of services to Maryland physicians in need of help. If you wish to help further the work of the Committee through a tax deductible donation send your check to: The Medical and Chirurgical Faculty Charitable/Educational Foundation, 1204 Maryland Avenue, Baltimore, Maryland 21201 Please note on your donation: "Physician Rehab"

Medical and Chirurgical Faculty of Maryland



Physician Rehabilitation Committee

WELCOME!

The Medical and Chirurgical Faculty of Maryland welcomes the new members listed below. They join an organization with a 196-year history of dedicated service to improving the health and welfare of the people of Maryland. With the help and expertise of longtime members and the participation and input of new members, Med Chi can continue its proud tradition of ensuring quality health care.

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Minutes of the Meeting of the House of Delegates
Saturday, January 28, 1995

▼ ***Members and guests present***

The list of members and guests present is available from the executive office of the Medical and Chirurgical Faculty of Maryland.

▼ ***Call to order***

The meeting was called to order at 2:00 p.m. by the speaker of the house, Allan D. Jensen, M.D., in Osler Hall of the Faculty building.

▼ ***Invocation***

The speaker asked all present to stand for the invocation. Rev. William N. McKeachie, St. Paul's Church, Baltimore, delivered the invocation.

▼ ***Report of the Credentials Committee***

Melvin S. Rapelyea, M.D., chairperson of the Credentials Committee, reported a quorum was present. (A total of 119 delegates were present.)

▼ ***Approval of minutes***

The minutes for the September 9 and September 11, 1994, meetings were approved as presented.

▼ ***Introduction/congratulations***

The speaker welcomed Paul Markowski, AMA State Representative. The speaker also noted that Edward Shanbacker, former executive director for Montgomery County, had accepted the position of executive director for the District of Columbia Medical Society and that Diane Briggs, the former executive director for Prince George's County Medical Society, will be assuming the executive directorship of the Montgomery County Medical Society. Dr. Jensen extended Med Chi's congratulations to both Mr. Shanbacker and Ms. Briggs.

▼ ***Report of the speaker of the house***

The speaker welcomed the delegates to the third meeting of the House since its reorganization and noted the outstanding number of delegates present at the meeting. For those who had not been present previously, the speaker discussed the reorganization of Med Chi and noted that House meetings are now held quarterly. He also noted that the Retreat Committee was responsible for the redesign of Med Chi's organizational structure and remarked that the committee structure had been enhanced by the reduction of standing committees and establishment of a council structure. Med Chi now has eight councils under which all committees fall. In addition, two committees—the Finance Committee and the Personnel Committee—fall under the purview of the Board of Trustees. The speaker concluded by stating that although Med Chi has made much progress, it still has many challenges to face.

▼ ***Honorary resolutions and awards***

- **Honorary resolutions**

  The speaker noted the honorary resolutions for John Hopewell Hebb, M.D., and Margaret L. Sherrard, M.D., submitted by Baltimore County Medical Association, which were as follows:

  a. John Hopewell Hebb, M.D.

  RESOLVED, That the House of Delegates of the Medical and Chirurgical Faculty of Maryland adopt this resolution as recognition of their appreciation of the time and effort Dr. Hebb has given to the Faculty, the Baltimore County Medical Association and the AMA; and be it further

  RESOLVED, That this resolution act as an expression of Dr. Hebb's colleagues' appreciation of his leadership in organized medicine.

  b. Margaret L. Sherrard, M.D.

  RESOLVED, That the House of Delegates of the Medical and Chirurgical Faculty of Maryland adopt this resolution as recognition of the high esteem in which Margaret L. Sherrard, M.D., is held by her physician colleagues and friends in the Faculty; be it further

  RESOLVED, That this resolution act as an expression of Dr. Sherrard's colleagues' appreciation of her leadership as Health Officer of Baltimore County; be it further

  RESOLVED, That the members of the Medical and Chirurgical Faculty of Maryland wish Margaret L. Sherrard, M.D., continued good health and happiness in her retirement.

  The resolutions were approved as presented.

- **Awards**

  The speaker presented two Governor's Citations of Excellence to Hiroshi Nakazawa, M.D. The first citation was for the instrumental part Dr. Nakazawa played in Maryland to establish a sister state relationship with the Kanagawa Prefecture in Japan.

  The second citation was presented for Dr. Nakazawa's work as the statewide coordinator of the Doctor/Lawyer/Teacher Partnership Against Drugs program. It was noted that since May 1990, almost 45,000 students from all over the state have benefited from the program.

▼ *Keynote speaker*

The keynote speaker was Martin P. Wasserman, M.D., the newly appointed secretary to the Department of Health and Mental Hygiene and a physician highly involved in Med Chi through his participation as a chairperson of the Council on Scientific Affairs, Public Health, and the Domestic Violence Task Force. Dr. Wasserman began by stating that both he and the newly appointed governor, Parris Glendening, expect to be in their positions in the twenty-first century.

Dr. Wasserman gave an overview of the Department of Health and Mental Hygiene, and through his speech tried to "shape the confusion" about the department. He explained his "Health Pledge to the People"; the Maryland Code that empowers the department; and the department's organization, budget, and staffing. He said the department's mandate is to "serve people," and that the department does this through its Medicaid, Licensing and Certification, Regulatory Commissions, and Boards and Commissions programs under its organizational structure.

As an aside, Dr. Wasserman discussed the AIDS name reporting controversy and said many people feel that this matter should be put before the legislature during this general assembly. However, Dr. Wasserman said that Governor Glendening, from what he assumes from conversations with him, would not support AIDS name reporting and if such legislation did pass, the governor would probably veto it.

▼ *Legislative overview*

The Honorable Thomas L. Bromwell, chairman of the Senate Finance Committee, and The Honorable Michael E. Busch, chairman of the House Economic Matters Committee, gave the delegation a brief overview of health care issues coming before the general assembly during the upcoming session. All health care legislation goes before these two committees.

▼ *President's report*

Donald H. Dembo, M.D., president, spoke about the division of physicians caused by the united agenda of insurance companies and managed care organizations. He said many of the topics physicians are divided on include: single payer, all payer, indemnity, point-of-service, any willing provider, and patient access. Dr. Dembo felt that physicians had turned on themselves, that one doctor is competing against another for a larger share of the patient pool and that doctors are their own enemies.

Dr. Dembo then discussed what Med Chi has done to unite physicians: programs in domestic violence; key participants in antismoking and other societal issues of destructive lifestyles; high profile response to BlueCross BlueShield of Maryland's efforts to go public and further erode physicians' practices and the needs of their patients; and improved relationships with legislators and regulators.

Dr. Dembo then noted how Med Chi's reorganization is working, through the reference committee structure that brings physicians together to be heard. He concluded by admonishing the physicians to finish their work and to foster Med Chi esteem, not its interpolitical turmoil.

▼ *Treasurer's report*

The treasurer, Carol W. Garvey, M.D., referred to the list of emeritus and waiver of dues requests, which had been included with the House of Delegates materials, and asked for its approval. The House of Delegates approved the emeritus and waiver of dues requests.

The treasurer also presented an updated financial report of the Medical and Chirurgical Faculty of Maryland. She said that although it was expected that there would be a decrease in dues-paying members with Med Chi's increase in dues, the opposite has happened. Med Chi has received an increase in membership revenue. Med Chi also received in November 1994 the payments for Peer Review and Physicians Rehabilitation from the Board of Physician Quality Assurance in the amount of $486,700.

It was also noted that Med Chi anticipates purchasing 1202 Maryland Avenue for more space for the Med Chi Agency necessitated by the effects of House Bill #1359. The building will be paid for through Med Chi's Insurance Trust Fund and will generate income from the Med Chi Agency. It was emphasized that the purchase is in no way connected to Med Chi's operating budget.

The last discussion concerned reimbursement for the lobbyist, which was $27,200 above the budgeted amount. Med Chi has taken $1,500 and $25,700 from internal savings to cover the increased amount. It was also noted that internal

savings have been realized from delayed hires and a reorganization of budgeted expenses for the Annapolis office.

The treasurer concluded that Med Chi may have more money at the end of the year in its contingency fund than it originally expected.

▼ *AMA delegation report*

George S. Malouf Sr., M.D., chairperson of Med Chi's AMA delegation, said the AMA highlights had been forwarded to all House attendees and suggested that they review the information. Dr. Malouf stressed that the AMA process is democratic—that all views can be heard in reference committee and everyone has an opportunity to speak. Dr. Malouf closed his talk by noting that the AMA has the best system in the world in that physicians can be heard on both a state and national level. Dr. Malouf also noted that a videotape of the speech given by Robert McAfee, M.D., president of the AMA, would be presented by the CEO.

▼ *Chief executive officer's report*

Angelo J. Troisi, F.A.C.H.E., chief executive officer, said two booklets had been prepared for attendees. Part I comprised newspaper articles on health care reform and Part II, newspaper articles on BlueCross BlueShield of Maryland.

The CEO showed a videotape of the speech given by Robert McAfee, M.D., AMA president, at the recent AMA interim meeting in Hawaii, in which he used a humorous medieval allegory to make a serious point about health care reform.

▼ *Update of MPI*

In the absence of Michael Epstein, M.D., chairperson of the Interim Board, Allan D. Jensen, M.D., the speaker of the house and a member of MPI, gave an update.

▼ *Personnel Committee report*

Paul A. Stagg, M.D., reported on the progress of the Board of Trustees' Personnel Committee. The Personnel Committee's function is to evaluate the chief executive officer. Dr. Stagg noted that since its first meeting in August, the committee has looked at other systems that have a CEO and that the committee has been able to come up with a fair and objective evaluation tool. He also noted that the committee has reviewed the CEO's contract and it has coordinated proper documents with him. Dr. Stagg noted that the bottom line in all these deliberations was to be fair to both the organization and the CEO. Dr. Stagg mentioned that the chairpersons of the councils and component society presidents were also contacted in the ongoing evaluation process. He stressed that all these steps have taken more time than had been anticipated. He concluded by noting that the committee was still working on the actual evaluation and that it would meet again in a couple of weeks and pursue completing the task. A report will be made to the Board of Trustees, which will take whatever action may be necessary.

▼ *Report of councils*

- **Council on Medical Services**

  Joseph S. Fastow, M.D., chairperson of the Council on Medical Services, introduced Howard Siegel, M.D., who reported on BlueCross BlueShield of Maryland's (BCBSM) recent reorganization and physician reimbursement reduction hearing before the Maryland insurance commissioner. He said Med Chi worked diligently to combat this effort. Meetings were held and testimony was given at the hearing by Drs. Siegel and J. Leonard Lichtenfeld, as well as by members of Med Chi staff (Rose M. Matricciani, R.N., J.D., chief operating officer; Angus R. Everton, Esq., general counsel; and Glen C. Burger, CPA, controller). BCBSM lost its bid to reorganize and the physician reimbursement issue is still being considered. Dr. Siegel thanked everyone involved for all their hard work.

- **Council on Legislation**

  Both Hilary T. O'Herlihy, M.D., chairperson of the Council on Legislation, and Joseph Schwartz, Esq., reported on upcoming legislative issues of interest to Med Chi members, including patient access and ambulatory surgical centers.

- **Council on Planning and Development**

  John Gordon, M.D., chairperson of the Council on Planning and Development, noted that goals and focus had been developed for a Med Chi public relations campaign as follows:

  - *Goals:* To improve the image of physicians with the public; to provide backup for legislative issues (e.g., patient access); and to increase membership.
  - *Focus:*
    - Campaign that supports Med Chi's legislative efforts regarding patient access legislation. Dr. Gordon said this was the immediate focus, that it had been approved by the Board of Trustees, and that a media packet was being developed.

      Patient education campaign on choosing a health care plan. A pamphlet entitled *Choosing Your*

Health Plan had been completed and copies were available for distribution at today's meeting.

- Developing a media/information packet about Med Chi that would be used for recruitment and media/information programs.
- Public service announcements campaign that would place public service announcements, stating "brought to you by Med Chi," about a variety of health-related issues on TV, radio, billboards, and newspapers.
- Developing position papers for Med Chi and providing media training for Med Chi spokespeople.
- Conducting a survey of physicians to collect data about the amount of charitable care given by physicians. Survey results would be used to support legislative and public relations initiatives.

- **Council on Ethical and Judicial Affairs**

Marianne Benkert, M.D., chairperson of the Council on Ethical and Judicial Affairs, reported that she and several other physicians had met with Joseph Schwartz, Esq., Med Chi lobbyist, to discuss the "death with dignity" bill. Dr. Benkert said it is basically a physician-assisted suicide bill, which is being sponsored by Delegate Dana Dembrow. Dr. Benkert noted that the Legislative Committee did not take a position on the bill. She also noted that the AMA Council on Ethical and Judicial Affairs had taken the position that physician-assisted suicide is contrary to medical ethics. She noted that a copy of the AMA report had been forwarded to Med Chi's Board of Trustees.

Report of reference committees

- **Reference Committee A**

The members of Reference Committee A were Allan T. Leffler, M.D., chairperson; Willarda V. Edwards, M.D.; William H. Goldiner, M.D.; and Stephen W. White, M.D. Dr. Edwards presented the committee's report (copy on file in the executive office of the Medical and Chirurgical Faculty of Maryland).

Resolution 1-95, Bill of Rights for Managed Care and Panel Physicians

Reference Committee A supported the resolution and recommended referring it to the Board of Trustees to prepare it for presentation at the June meeting of the AMA and to report back to the House of Delegates at its next meeting. A substitute resolution was made by David Nagel, M.D., on behalf of Baltimore County Medical Association to delete the fourth resolve.

The House of Delegates approved the substitute resolution as follows:

RESOLVED, That the Medical and Chirurgical Faculty of Maryland stand by the following ten principles:

1. No physician shall be dropped from a panel for advocating for his patient.
2. Panel physicians shall be allowed to practice to the full extent of their licensure and training and shall be permitted to provide comprehensive services to their patients based on medical necessity.
3. Panel members shall help management develop procedures for telephone triage and referral of patients seeking an evaluation and treatment, including the necessary qualifications of the telephone triage personnel.
4. Panel physicians shall help management develop medical necessity criteria, review criteria, appeals criteria, and the professional qualifications needed to be a clinical reviewer.
5. Panel members shall help management develop the number and qualifications of the full range of clinical personnel needed on the panel of providers.
6. No panel member shall be subject to retribution for "whistle-blowing" activities.
7. Panel members who are threatened with being dropped from a panel are entitled to a hearing with "due process" and have the right of appeal.
8. Panel members shall have the right to organize and bargain collectively.
9. "Hold harmless" clauses are not permitted in contracts.
10. An insurance plan's expenditures for the medical care of the illnesses of any specialty shall be sufficient to provide that care of a quality equal to that delivered across specialties and shall allow for delivery of that care by providers with credentials as fine as those who provide the care for the illnesses of all other specialties; and be it further

RESOLVED, That the Medical and Chirurgical Faculty of Maryland establish these principles in a "Bill of Rights for Managed Care and Panel Physicians" to be maintained, disseminated, and episodically supplemented as responsibly needed to respond to the unpredictable trends in economic organizing; and be it further

RESOLVED, That these principles shall be individually collected and incorporated in Med Chi's legislative agenda and draft legislative proposals wherever expedient and feasible.

Resolution 3-95, Membership in the Med Chi Sponsored Managed Care Product

Reference Committee A recommended amending the resolution as originally presented. Another substitute amendment was presented, approved, and the amendment approved by the House as follows:

RESOLVED, That the Faculty assure that any Med Chi managed care product be written so that any qualified interested member shall be included who meets and continues to meet managed care products practice guidelines, policies and procedures.

Resolution 5-95, Excessive Health Insurance Industry Profits

Reference Committee A recommended referring the resolution to the Board of Trustees to study and to report back to the House of Delegates. This was approved with favorable sentiment by the House of Delegates. The resolution is as follows:

RESOLVED, That the Medical and Chirurgical Faculty of Maryland ask the state legislature to examine the issue of excessive health insurance industry profits with a view to placing reasonable limitations on the portion of industry income which is diverted from coverage of actual health care expenses.

Resolution 8-95, Economic Credentialing Resolution 9-95, Insurer/Provider Financial Disclosure

The Reference Committee recommended combining both resolutions with rewording for clarification. The Reference Committee's recommendation was approved as follows:

RESOLVED, That the Medical and Chirurgical Faculty of Maryland work legislatively or otherwise to have the health insurance industry fully disclose those criteria used in utilization profiling, i.e. economic credentialing, to the medical profession and to subscribers; and be it further

RESOLVED, That the Medical and Chirurgical Faculty of Maryland work legislatively and otherwise to have the health insurance industry and intermediaries fully disclose and explain financial reimbursement mechanisms such as capitation and bonuses to all potential subscribers.

Resolution 10-95, Any Willing Provider

Reference Committee A recommended approval of the resolution with rewording. An amendment was made from the floor but did not pass. Reference Committee A's recommendation was approved as follows:

RESOLVED, That the Medical and Chirurgical Faculty of Maryland work to implement the principle that patients should be able to select the physician of their choice in order to maintain the quality and continuity of their health care.

- **Reference Committee B**

  Reference Committee B's members were Beverly A. Collins, M.D., chairperson; Maurice B. Furlong, Jr., M.D.; David S. O'Brien, M.D.; and Howard M. Silby, M.D. (A copy of the committee's report is on file in the executive office of the Medical and Chirurgical Faculty of Maryland.)

BOT 1-94, Conduct of a Peer Review Prior to Litigation

Reference Committee B recommended that the Board of Trustees' recommendations to BOT 1-94 be amended. The recommendations were approved to read as follows:

1. That all components and interested persons identify cases in which the disclosure of a peer review investigation occurred and was detrimental to the case.
2. That if the information provided supports their contention that disclosure of a peer review prior to the conclusion of a malpractice action is detrimental, then the present laws concerning nondiscoverability of peer review actions be strengthened to explicitly state that the *existence* of a peer review is nondiscoverable or admissible in a civil action and possibly providing for monetary damages or penalties for the disclosure of this information.

BOT 2-94, Inappropriate Questions on Applications

Reference Committee B recommended that the Board of Trustees' recommendations to BOT 2-94 be amended. Its recommendations were approved as follows:

1. That all components and interested persons identify those hospitals which are asking inappropriate peer review questions.
2. That if the information provided indicates that these hospitals are acting outside of statutory and regulatory authority, that this issue be addressed by Med Chi's General Counsel.
3. That if the information provided indicates that the questions being posed are irrelevant or invalid, that this issue also be addressed by Med Chi's General Counsel.

Resolution 2-95, Confidentiality of a Dues Waiver Request

Reference Committee B recommended that the original resolution be amended. The amended resolution was approved as follows:

RESOLVED, That the identity of persons making a request remain confidential and not be in the minutes of the Board of Trustees, published in the *Maryland Medical Journal.*

Resolution 4-95, Patient Access Public Relations Campaign

Reference Committee B recommended that the House of Delegates accept withdrawal of Resolution 4-95. The House of Delegates accepted the recommendation.

Resolution 6-95, Standardized Laboratory Requisition Form

Reference Committee B recommended that the resolution be amended. The House of Delegates approved the recommendation as follows:

RESOLVED, That a standardized laboratory requisition form which clearly indicates the specific tests being ordered become mandatory and be it

RESOLVED, That the House of Delegates refer this resolution to the Legislation Committee for implementation.

Resolution 7-95, Legal Driving Age

Reference Committee B recommended that the original resolution be amended. An amendment to delete was made, but failed. Reference Committee B's recommendation was approved as follows:

RESOLVED, That the Med Chi Faculty support introduction into the Maryland General Assembly legislation which would raise the driving age to 17 while allowing for exemptions to be determined in regulation as necessary.

Resolution 11-95, HealthPlus Policy to Exclude Physicians Memorial Hospital

Reference Committee B could not take a position on this resolution because no one was present to speak on it. The resolution was withdrawn by the House after it was noted that its sponsor, Charles County Medical Society, had asked that it be withdrawn.

Resolution 12-95, Name Reporting of HIV Positive Individuals

Reference Committee B recommended an amended resolution be approved and that the reasons originally listed as support under the last resolve be incorporated as "Whereases." An amendment to the amended resolution was approved by the House after much discussion. The amended amendment was approved as follows:

RESOLVED, That the Medical and Chirurgical Faculty continue to support legislation to require name reporting of HIV positive individuals to the Department of Health and Mental Hygiene.

▼ ***Initiatives from components***

The following initiative was presented by Baltimore City Medical Society:

The Baltimore City Medical Society is concerned about the public health implications of medical cost-shifting that occurs when patients enrolled in Medicaid HMOs receive nonreimbursed medical care at non-HMO sites. This places a disproportionate financial load upon providers of last resort such as health departments and hospital emergency departments. Anecdotal reports suggest that this may be a substantial problem, particularly in areas such as Baltimore City with a large number of Medicaid HMO enrollees. We suggest that the appropriate committee within Med Chi study this issue to determine the extent of the problem, and, if appropriate, address the following concerns:

- Patients enrolled in Medicaid HMOs routinely receive medical services at community health centers and at health department sites due to the urgency of the problem or the logistic difficulty of obtaining such care at their HMO site. Provision of such care is apparently rarely, if ever, reimbursed by the HMO. It is suggested that the Department of Health and Mental Hygiene (DHMH) require documentation from Medicaid HMOs that they are providing services required by their contract, and that such services are not performed by other providers in a non-reimbursed fashion.
- Medicaid HMO patients are frequently seen for urgent and routine medical issues in emergency department settings. OBRA regulations, as they are currently interpreted, require physician evaluation and medical stabilization of any patient seeking treatment regardless of insurance status, thus resulting in hospital emergency departments providing care to Medicaid HMO patients without reimbursement. It is suggested that DHMH establish authorization protocols which require Medicaid HMOs to
  - reimburse hospital emergency departments for medical conditions which fit the ACEP definition of an emergency condition,

- disallow "retrospective authorization" under which emergency care is reimbursed only after review of treatment records, and
- document that the managed care organization is providing for emergency care as provided in their contract.

The House of Delegates referred this matter to the Council on Medical Services.

▼ *Initiatives from specialty societies*

Stuart Brager, M.D., the newly elected president of the Specialty Society Section, noted that this section had gone on record to support Med Chi in its efforts to fight BlueCross BlueShield of Maryland in its effort to go public and reduce physician reimbursement fees. Since the annual meeting when it was formed via the new Bylaws, the Specialty Society Section has been extremely active and has held several meetings. Members have elected officers—a president and a secretary-treasurer (Paul McClelland, M.D.) and are in the process of nominating names for the trustee position on the Board of Trustees.

▼ *Date of meetings*

The next meetings of the House of Delegates will be May 4 and 6, 1995, during the annual meeting of Med Chi to be held at the Conference Center in College Park, Maryland.

A meeting of the House, to be held at Med Chi, will be held on Saturday, July 15, 1995.

▼ *Adjournment*

There being no further business, the meeting was adjourned at 5:30 p.m. by the speaker of the house.

Respectfully submitted,
Paul A. Stagg, M.D.
Secretary

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The Med Chi membership directory is published annually. It lists, by county, the addresses, telephone numbers, specialties, board certifications, and specialty society affiliations of all Med Chi members, as well as photographs of Med Chi officers and component society presidents. Updated information about members is listed below. The following page contains the second page of specialty society codes which was inadvertently omitted from the 1995 directory.

- **BALTIMORE CITY**

Kulathungam, Saba
8020 Belair Rd.
Baltimore, MD 21236
410-668-3000
IM, CD; BC 020, 201; SS 264

- **CECIL COUNTY**

Heller, Melvin S.
2 Schiller Ave.
Narberth, PA 19072
215-667-3067
P, CHP: BC 075, 751; SS 516

- **HARFORD COUNTY**

Kim, Chul H.
114 W. Belair Ave.
Aberdeen, MD 21001
410-272-3377
PD, PDE; BC 055; SS 132

- **HOWARD COUNTY**

Afzal, Muhammad
Howard County Medical Center
9055 Chevrolet Dr., Ste. 203
Ellicott City, MD 21043
410-465-9455
GE, IM; BC 020, 203; SS 312, 384, 615

- **MONTGOMERY COUNTY**

McMurry, James F., Jr.
6318 Democracy Blvd.
Bethesda, MD 20817
301-493-4206
DIA, END, IM; BC 020, 202; SS 360, 960, 654

Shigo, John J.
18540 Office Park Dr.
Gaithersburg, MD 20879
301-330-3900
FP; BC 018

576 ..... Amer. Col. of Rheumatology
588 ..... Amer. Roentgen Ray Soc.
589 ..... Amer. Soc. of Clinical Hypnosis
590 ..... Amer. Soc. of Clinical Oncology Inc.
591 ..... Amer. Soc. for Aesthetic Plastic Surg., Inc.(1974)
600 ..... Amer. Soc. for Clinical Investigation
605 ..... Amer. Spinal Injury Assn.
606 ..... Amer. Soc. for Clinical Nutrition
612 ..... Amer. Assn. of Pathologists
615 ..... Amer. Soc. for Gastrointestinal Endoscopy (1971)
620 ..... Amer. Soc. for Head and Neck Surg.
624 ..... Amer. Soc. for Surg. of the Hand
630 ..... Amer. Soc. for Abdominal Surgeons
636 ..... Amer. Soc. of Anesthesiologists
638 ..... Amer. Soc. of Bariatric Pathologists
648 ..... Amer. Soc. of Clinical Pathologists
649 ... Amer. Soc. for Clinical Pharmacology and Therapeutics
650 ..... Amer. Soc. of Cytology
651 ..... Amer. Soc. of Dermatologic Surg.
652 ..... Amer. Soc. of Hematology
654 ..... Amer. Soc. of Internal Medicine
655 ..... Amer. Soc. of Maxillofacial Surgeons
656 ..... Amer. Soc. of Nephrology
659 Amer. Soc. of Ophthalmic Plastic & Reconstructive Surg.
660 ... Amer. Soc. of Ophthalmic & Otolaryngologic Surg. Inc.
672 ..... Amer. Soc. of Plastic & Reconstructive Surg.
675 ..... Amer. Soc. of Therapeutic Radiologists
684 ..... Amer. Surgical Assn.
696 ..... Amer. Thoracic Soc.
708 ..... Amer. Urological Assn.
715 ..... Assn. of Bone and Joint Surgeons
720 ..... Assn. of Military Surgeons of U.S.
744 ..... Assn. of Amer. Physicians
756 ..... Assn. of Life Insurance Med. Directors of America
758 ..... Assn. of State and Territorial Health Officers
760 ..... Assn. of Teachers of Preventive Medicine
764 ..... Assn. of University Radiologists
768 ..... Central Assn. of Obstetricians and Gynecologists
780 ..... Central Neuropsychiatric Assn.
792 ..... Central Soc. for Clinical Research
804 ..... Central Surgical Assn.
816 ..... Clinical Orthopaedic Soc.
828 ..... Col. of Amer. Pathologists
840 ..... Congress of Neurological Surgeons
842 ..... Contact Lens Assn. of Ophthalmologists, Inc.
844 ..... Eastern Psychoanalytic Assn.
845 ..... Fifty Year Club of Amer. Medicine - New
846 ..... Fifth Year Club of Amer. Medicine - Life
852 ..... The Amer. Assn. of Neurological Surgeons
864 ..... Amer. Occupational Medical Assn.
868 ..... Infectious Diseases Soc. of America
876 ..... Intl. Acad. of Pathology
877 ..... Intl Acad. of Pathology: U.S. - Canada
879 ..... Intl. Acad. of Proctology
881 ..... Intl. Anesthesia Research Soc.
885 ..... Intl. Cardiovascular Soc.
888 ..... Intl. Col. of Surgeons
890 ..... Intl. Soc./Advcmnt. of Humanist Study - Gynecology
900 ..... Intl. Soc. of Surg.-Amer. Branch
902 ..... Joint Council of Allergy and Immunology
904 ..... Soc. of Surgical Oncology
905 ..... Natl. Assn. of Medical Examiners
907 ..... Norman F. Miller Gynecologic Soc.
908 ..... Plastic Surg. Research Council
909 ..... Soc. for Adolescent Medicine
910 ..... Soc. of Military Ophthalmologists (1971)
911 ..... Soc. of Investigative Dermatology
912 ..... Radiological Soc. of North America
913 ..... Soc. of Medical Consultants to the Armed Forces
914 ..... Soc. for Pediatric Radiology
915 ..... Soc. for Surg. of the Alimentary Tract
916 ..... Soc. for Critical Care Medicine
918 ..... Soc. of Head & Neck Surgeons
920 ..... Soc. of Nuclear Medicine
922 ..... Soc. of Neurological Surgeons
923 ..... Soc. of Teachers of Family Medicine
924 ..... Soc. of University Surgeons
925 ..... Soc. of Perinatal Obstetricians
926 ..... Soc. for Gynecologic Investigation
927 ..... Soc. of Gynecologic Oncology
928 ..... Soc. of Reproductive Endocrinologists
929 ..... Soc. of Reproductive Surgeons
936 ..... Southeastern Surgical Assn.
948 ..... Southern Surgical Assn.
949 ..... The Assn. of Veteran's Administration Surgeons
950 ..... The Soc. of Thoracic Surgeons
952 ..... Renal Physicians Assn.
954 ..... The Southwestern Surgical Congress
960 ..... The Endocrine Soc.
970 ..... Univ. Assn. for Emergency Medical Services
972 ..... Western Surgical Assn.
980 ..... Woman's Auxiliary-AMA Pension Program Only

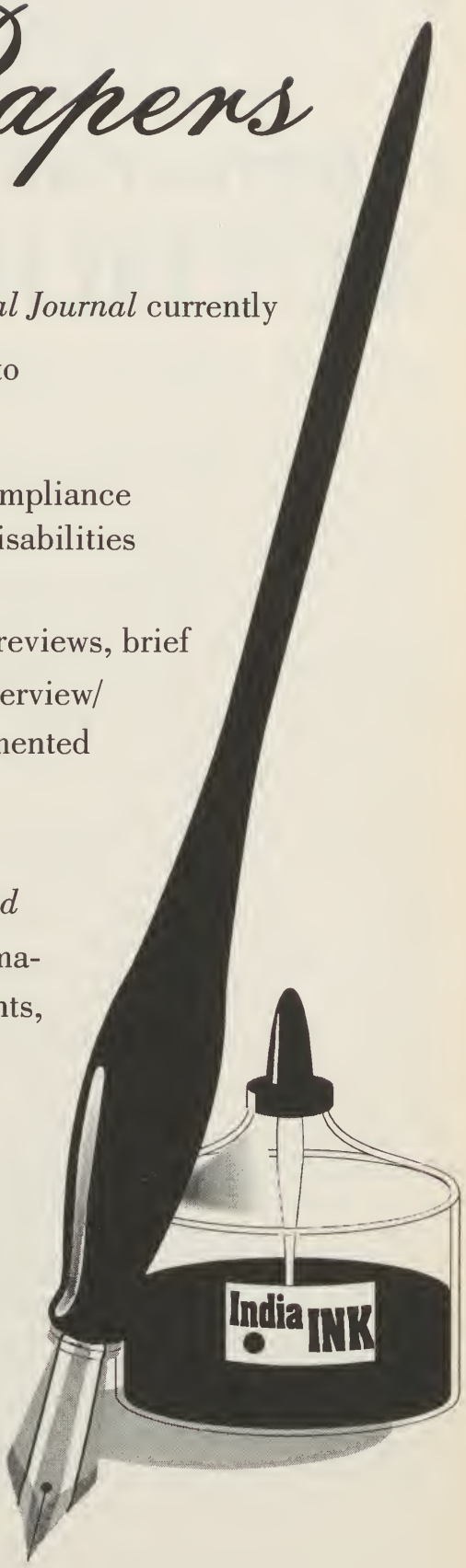
Call for Papers

The Editorial Board of the *Maryland Medical Journal* currently seeks original articles addressing topics related to

- Drug Interactions in the Elderly
- Strategies for Enhancing Therapeutic Compliance
- Assistive Technologies for People with Disabilities

Papers may be original research, literature reviews, brief reports, case histories accompanied by a brief overview/ summary of the relevant literature, or well-documented opinions about future trends.

All submissions should conform to *Maryland Medical Journal* requirements. For further information or to obtain a copy of submission requirements, contact Mary Ann Ayd, Managing Editor,
1211 Cathedral Street, Baltimore, MD 21201;
410-539-0872 or 1-800-492-1056;
FAX 410-547-0915.



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Information for AUTHORS

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  All material, including references, tables, and legends, must be double-spaced. Pages should be numbered. (All abbreviations should be spelled out on first use.) The original manuscript plus one copy should be submitted on standard (8.5" x 11") bond paper. If at all possible, an IBM-compatible disk should be included, with the manuscript entered in a WordPerfect, Multimate, Wordstar, or ASCII format; the transmittal letter should identify the format used.

- ***References***—References are limited to those citations noted in the text. References should be numbered consecutively as they appear in the text and should be kept to a minimum (fewer than thirty-five). Personal communications and unpublished data are not acceptable. At a minimum, references should include names of all authors, complete title of the article cited, name of journal abbreviated according to *Index Medicus* (if abbreviation is not known, journal name should be spelled out fully), year of publication, volume number, and first and last page numbers. Sample references are as follows:

  1. Stevens MB. The clinical spectrum of SLE. Md Med J 1991; 10:875–85.
  2. Ropes MW. Characteristics, manifestations, and pathologic findings. In: Ropes MD, ed. Systemic Lupus Erythematosus. Cambridge, MA: Harvard University Press. 1976; 50–4.

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- ***Illustrations***—Illustrations include material that cannot be set in type. Photographic material must be submitted as high-contrast, glossy prints. Drawings and graphs must be done professionally in india ink on high-grade white drawing paper or be computer generated. Identification—including figure number, the title of manuscript, the name of corresponding author, and arrow indicating top—should be typed on a gummed label and affixed to the back of each illustration. Legends for illustrations should be typed on a separate page with numbers corresponding to those on the photographs or drawings. Recognizable photographs of patients are to be masked and should carry with them written permission for publication. Cost of printing color photographs must be borne by the author.

Checklist

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Miscellaneous meetings

1995 Risk management program: suit survival/lessons in risk management, sponsored by Medical Mutual Liability Insurance Society of MD. Med Mutual members who attend will receive a 5% discount on 1996 renewal premium. 2 Cat 1 AMA credits. Fee: $40. Info: Toni Davis or Natalie Poole, 410-785-0050 or 1-800-492-0193.

Medical Mutual, Hunt Valley	**April 6**
Memorial Hospital, Cumberland	**April 12**
Anne Arundel Med. Ctr., Annapolis	**April 13**
Physicians Memorial, LaPlata	**April 18**
Harford Memorial, Havre de Grace	**April 20**
Howard County General, Columbia	**April 27**

Third world congress on stress, trauma and coping in the emergency services professions, at the Sheraton Inner Harbor Hotel, Baltimore, MD. Info: 410-730-4311. **April 19–23**

Mental health services for older adults: building a regional continuum of care conference, at the Sheppard Pratt Conference Center, Baltimore, MD. 5.75 Cat 1 AMA/PRA credits. Fee: TBA. Info: 410-938-4598. **April 22**

Clinical innovations in OB/GYN ultrasound, sponsored by Meetings & Management Techniques Plus and The American Institute of Ultrasound in Medicine, at the Lowes L'Enfant Plaza, Washington, DC. 14.5 Cat 1 AMA/PRA credits and 15 Formal Learning Cognates by ACOB/GYN. Info: Ann Boehme, 516-561-4223. **April 22–23**

Promoting enteral options in nutrition support, annual conference of the Maryland Society of Parenteral and Enteral Nutrition, at the Inn and Conference Center, University of Maryland University College, College Park, MD. Info: 410-880-8233 **April 24, 1995**

Caring for the diabetic lower extremity: a practical approach for primary health care providers, sponsored by the American Diabetes Assoc., MD Affiliate and the MD Podiatric Medical Assoc., at the Sheraton International Hotel, BWI Airport. 7 Cat 1 AMA credits and 7 credit hours by the Maryland Board of Podiatric Examiners. $125/physicians; $100/ACP members; $75/other health professionals. Info: 410-526-2900. **April 28**

The Medical and Chirurgical Faculty of Maryland's 1995 annual meeting, at the Inn and Conference Center, College Park, MD. Info: 410-539-0872. **May 4–5**

Clincal auscultation of the heart, sponsored by the American College of Cardiology, at the Georgetown University Medical Center in Washington, DC. 18 Cat 1 AMA credits. Info: 800-257-4739. **May 10–12**

Current concepts in orthopedics, sponsored by the Southern Medical Association and the Southern Orthopedic Association at the Harbor Court Hotel in Baltimore, MD. Cat 1 AMA credits available. Fees: $295-$495. Info: Michelle Williamson, 800-423-4992. **May 19–21**

Third international symposium on maritime health, sponsored by the George Washington University Medical Center, at the Maritime Institute of Technology and Graduate Studies, Baltimore, MD. 14 Cat 1 AMA credits. $1350 (includes lodging and some meals). Info: Karen Mayer, 202-994-3921. **June 7–9**

2nd Annual intensive review of internal medicine, sponsored by the George Washington University Medical Center, at the Washington Marriott Hotel, Washington, DC. Info: Deborah Grant, 202-994-4285. **June 7–10**

Miscellaneous meetings (continued)

3rd Annual board review in family medicine, sponsored by the George Washington University Medical Center, at the Marriott Crystal Gateway Hotel, Arlington, VA. 39 Cat 1 AMA/AAFP credits. Info: Maria Gorrick, 202-994-4285. — **June 24–28**

6th Biannual gastroenterology board review course, sponsored by the George Washington University Medical Center, at the Grand Hyatt, Washington, DC. Fee and credits TBA. — **Oct. 7–11**

Medical oncology board review course, sponsored by the George Washington University Medical Center, at the Ritz-Carlton Pentagon City, Arlington, VA. Fee and credits TBA. — **Oct. 8–12**

Continuously throughout the year

Fluorescein angiography conference, sponsored by the Retina Center, Saint Joseph Hospital, Baltimore, MD, first and third Mondays of each month; 8:00–9:00 am. Fee: none. Info: R. Classon, 410-337-4500.

The Johns Hopkins Medical Institutions

All courses at the Thomas B. Turner Building unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Medical Education, 720 Rutland Ave., Baltimore, MD 21205 (410-955-2959).

Clinical care of the patient with HIV infection, at the Stouffer Harborplace Hotel, Baltimore, MD. 12.5 Cat 1 AMA credits. $325/physicians; $175/residents, fellows, and allied health professionals. — **April 6–7**

Current concepts in thyroid disease: update 1995, 8.5 Cat 1 AMA credits. $160/physicians; $30/residents and fellows. — **April 21**

Ninth annual mood disorders symposium, Cat 1 AMA credits pending. $50/DRADA members; $60/other. — **April 25**

Wilmer nursing conference — **April 28**

Pediatric allergy and immunology for the practitioner, 14 Cat 1 AMA credits. $255/physicians; $175/residents and allied health professionals. — **May 4–5**

Contemporary issues in the diagnosis and treatment of low back pain — **May 4–6**

In vitro toxicology — **May 8–10**

Rheumatology nursing — **May 12–13**

40th Annual topics in clinical medicine, 39.5 Cat 1 AMA credits, 37 prescribed credits by AAFP. Fee: $750/physicians; $600/residents, fellows, others. — **May 15–19**

Advanced pediatric life support, 20 Cat 1 AMA credits. — **June 12–14**

Design and analysis in clinical trials, 15 Cat 1 AMA credits. — **June 15–16**

Continuously throughout the year

Visiting preceptorship in pediatric critical care medicine. Ongoing five-day preceptorship by appointment. 40 Cat 1 AMA/PRA credits. $600.

The Johns Hopkins Medical Institutions (continued)

The department of radiology and radiological sciences offers several courses in abdominal and obstetrical ultrasound. Info: P. Williams, 410-955-3169.

Visiting physicians. Offered throughout the year for experience in the lab and participation in read-in sessions; by appointment only. 40 Cat 1 AMA/PRA credits. $500.

Johns Hopkins medical grand rounds. Accredited audiovisual continuing education series of case discussions for clinicians; 30 topics per year in five bimonthly programs. Individual and group subscriptions. 40 Cat 1 AMA/PRA credits. Info: 410-955-3988.

Johns Hopkins sports medicine grand rounds. Accredited continuing education series of case discussions by a different presenter on the first Thursday of each month. Info: Carol Kelly, 410-383-0600.

University of Maryland

For each course, additional information may be obtained by contacting the Program of Continuing Education, University of Maryland School of Medicine, Room 14-011, BRB, 655 W. Baltimore St., Baltimore, MD 21201 (410-706-3956) or by calling the phone number listed after a specific program. FAX 410-328-3103.

Noninvasive vascular testing—the whole story, at Harbor Court Hotel, Baltimore, MD. 15 Cat 1 AMA credits. Fee: $325/physicians; $250/techs. Info: Judith Brannan 1-800-982-2011. **April 21–22**

Maryland Otolaryngology, Head & Neck Surgical Society: resident research presentations, at the Greater Baltimore Medical Center, Towson, MD. 3 Cat 1 AMA credits. $165. Info: J.F. Biedlingmaier, M.D., 410-225-8072. **April 25**

PHYSICIAN'S RECOGNITION AWARD

During January 1995, the physicians listed below received the American Medical Association (AMA) Physician's Recognition Award. Established in 1968, the award's purpose is to encourage physician participation in continuing medical education and to recognize those physicians who have voluntarily completed programs of continuing medical education.

Robert J. Bauer, M.D.
Sanders H. Berk, M.D.
Manuel S. Cockburn, M.D.
Richard A. DeSantis, M.D.
Julie A. Hartley, M.D.
Ramesh K. Khurana, M.D.
Seymour Levine, M.D.
Murli N. Mathur, M.D.
Neil A. Meade, M.D.
Bernard Stopak, M.D.
Vivek C. Vaid, M.D.

University of Maryland

8th Annual trauma anesthesia & critical care symposium, at the Hyatt Regency Hotel, Baltimore, MD. 18.5 Cat 1 AMA credits. Fee: $595. Info: Kimberly Unitas, 410-328-2399. **May 11–13**

Physician forum HIV: beyond the recommendations—how we really care for AIDS patients, at the Brass Elephant Restaurant, Baltimore, MD. 1 Cat 1 AMA credit. Info: Sylvia Scherr, 410-328-8639. **May 18**

Focus on fever, at the Marriott Inner Harbor Hotel, Baltimore MD. 5 Cat 1 AMA credits. Fee: $75. Info: Jack Blalock, 410-605-7199. **June 10**

21st Annual family medicine review course, at the Princess Royale Ocean Suite Hotel, Ocean City, MD. Cat 1 AMA/AAFP credits. Info: Althea Pusateri, 410-706-3956. **June 25–30**

Managing emergency medical services, at the University of Maryland Baltimore County (UMBC). Sponsored by the UMBC Department of Emergency Health Services and the Maryland Institute for Emergency Medical Services Systems. Info: Dr. Richard Bissell, 410-455-3776. **July 2–28**

1995 Advanced pre-operative evaluation and planning for complex deformities, at the Pikesville Hilton Inn, Baltimore, MD. 25 Cat 1 AMA credits, Fee: $450. Info: Steven Kaniecki, 410-448-3394. **Sept. 16–19**

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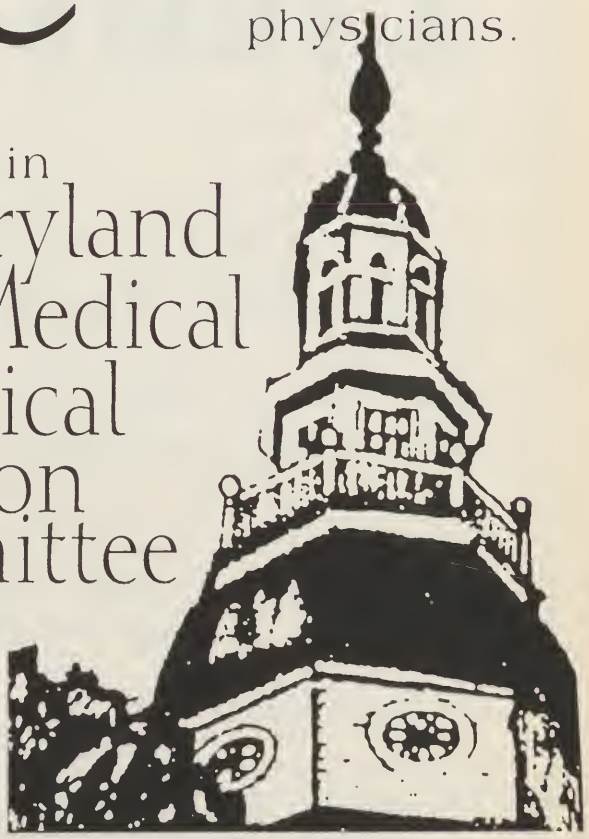
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April, 1995
RABIES PREVENTION IN MARYLAND

The following is an update and revision of "Questions and Answers on Rabies" presented in the Maryland Medical Journal, September 1984. Rabies Prevention - United States, 1991, Recommendations of the Immunization Practices Advisory Committee (ACIP), including 86 references, is available as a useful guide by telephoning 410-225-6711. The package insert for each of the antirabies biologics must be consulted when administering these products.

Maryland has become involved in an epizootic of raccoon rabies. The outbreak began in Allegany County in 1981 following a decade of almost no rabies in four-footed animals.

It is expected that rabies will be enzootic for many years. Approximately 80% of the cases are in the raccoon which is the only maintenance host, although there is spillover into skunks, foxes, cats, dogs, groundhogs, and other wild and domestic species. Somerset County was the last Maryland jurisdiction to become involved in March of 1993. Bat rabies activity, which is unrelated to the raccoon epizootic, continues to occur.

Rabies is an almost invariably fatal, acute virus encephalomyelitis once signs and symptoms occur.

Onset is with a sense of apprehension, headache, fever, malaise and indefinite sensory changes often referred to the site of the bite wound. The disease progresses to paresis or paralysis; spasm of muscles of deglutition on attempts to swallow leads to fear of water (hydrophobia); delirium and convulsions follow. Without supportive medical intervention, the usual duration is 2 to 6 days, sometimes longer; death is often due to respiratory paralysis.

Three factors must be considered for evaluation before specific antirabies treatment is initiated.

1. The type, nature and extent of exposure.
2. The animal species involved.
3. The circumstances of the bite incident or possible exposure.

When there may be multiple exposures to rabies in a single episode, each possible exposure must be evaluated individually. If there has been no exposure, postexposure prophylaxis (PEP) is not necessary.

Rabies is transmitted only when the virus is introduced into open cuts or wounds in skin or in mucous membranes.

The virus is found in saliva and other potentially infectious material (such as brain tissue). If these materials containing the virus are dry, the virus can be considered noninfectious.

Carnivore animals and bats are most likely to be rabid. Rodents have not been known to cause human rabies in the United States.

The majority of rabies cases occur in raccoons and a significant number of rabid fox, skunk, and bats are identified. Rabid dogs and especially cats represent a great risk to humans because of their close association with people. Rabies in rodents, such as squirrels, chipmunks, rats, mice, voles, and rabbits and in insectivores (moles and shrews) is rare. Rabies in caged rodents, such as hamsters, guinea pigs, gerbils, rats, and mice is almost unknown. The groundhog (woodchuck) which is a large wild rodent is an exception and regularly tests positive for rabies because of its close association in the wild with raccoon.

The circumstances surrounding a potential exposure are important.

An unprovoked attack by a domestic animal is more likely than a provoked attack to indicate that the animal is rabid. Bites inflicted on a person attempting to feed, pet, or handle an apparently healthy cat, dog, or farm animal or during territorial encroachment should generally be regarded as provoked.

A fully vaccinated dog or cat is unlikely to be rabid.

The 10-day quarantine/observation period imposed upon an apparently healthy owned domestic animal that bites will appropriately protect human health. Unowned, stray, or feral domestic animals, and wild and exotic animals that bite should be immediately tested for rabies.

There are two types of rabies exposures, bite and nonbite.

A bite is any penetration of the skin by the teeth. The site of a bite should not influence the decision to begin PEP treatment even though bites to the face and hands carry the highest risk.

Nonbite exposures are scratches from a rabid animal or other scratches, abrasions, open wounds, or mucous membranes contaminated with saliva or other infectious material (such as brain tissue) from a rabid animal. Other contacts by themselves, such as petting a rabid animal or contact with blood, urine, feces, or guano does not constitute an exposure. Nonbite exposures rarely cause rabies.

Immediate and thorough washing of all wounds and scratches with soap and water is an important measure for preventing rabies.

Simple local wound cleansing has been shown to reduce markedly the likelihood of rabies. Tetanus prophylaxis and measures to control bacterial infection should be given as indicated. After a completed primary tetanus vaccination (3 absorbed tetanus toxoid), a booster is appropriate if the patient has not received tetanus toxoid within the preceding 5 years in accordance with the current ACIP recommendations.

The decision to suture large wounds should take into account cosmetic factors and the potential for bacterial infection.

Persons who have been bitten by animals suspected or proven rabid should begin postexposure treatment within 24 hours.

Treatment should be administered as soon as possible regardless of the interval from the time of exposure. However, there have been instances when the decision to begin treatment was not made until many months after the exposure because of a delay in recognition that an exposure had occurred. Incubation periods of greater than 1 year have been reported.

Postexposure prophylaxis includes the administration of both rabies vaccine, Human Diploid Cell Vaccine (HDCV), and passive antibody, Human Rabies Immune Globulin (HRIG), in most instances.

PEP antirabies vaccination should always include the administration of both vaccine and passive antibody with the exception of persons who have previously received complete vaccination regimens (preexposure or postexposure) with a cell culture vaccine or have a documented rabies antibody titer.

The PEP regimen of HDCV and HRIG is recommended for both bite and nonbite exposures regardless of the interval between exposure and initiation of treatment.

PEP consists of five 1.0 ml doses of HDCV administered intramuscularly in the deltoid area for adults. For children, the anterolateral aspect of the thigh is acceptable. The gluteal area should never be used. After the first dose of vaccine (day 0), additional doses are given on days 3, 7, 14 and 28, respectively.

Human Rabies Immune Globulin is administered intramuscularly only once at the same time as the first dose of vaccine. The dosage of HRIG is 20 I.U./kg for all age groups and all body weights (i.e., emaciation, obesity, pregnancy). No more than the recommended dose should be given.

If anatomically feasible, up to one-half the dose of HRIG should be thoroughly infiltrated in the area around the wound and the balance administered intramuscularly in the gluteal area. HRIG should never be administered in the same syringe or into the same anatomical site as vaccine.

There is no evidence that hepatitis B virus (HBV), human immunodeficiency virus (HIV), or other viruses have ever been transmitted by commercially available HRIG in the United States.

Postexposure prophylaxis is effective in preventing rabies after exposure.

No treatment failures have occurred in the United States. In each of 7 cases of rabies contracted after receiving PEP outside of the United States some deviation from the recommended regimen protocol was documented. Specifically, patients who contracted rabies did not have their wound cleansed with soap and water, did not receive their vaccine injected in the deltoid (i.e., vaccine was administered in the gluteal area), or did not receive passive vaccination (i.e., HRIG) around the wound site.

Adverse reactions after PEP vaccination with HDCV are less serious and less common than with previous vaccines.

Local reactions such as pain, erythema and swelling or itching at the injection site have been reported among 30% - 40% of recipients. Systemic reactions such as headache, nausea, abdominal pain, muscle aches, and dizziness have been reported in 5%-40% of recipients.

Three cases of neurologic illness, resembling Guillian-Barré syndrome that resolved without sequelae in 12 weeks have been reported. A causal relationship has not been established for a few other subacute central and peripheral nervous system disorders which have been temporally associated with HDCV.

Local pain and low-grade fever may follow receipt of HRIG. Other reactions have not been reported specifically for HRIG as have been reported after injection of immune globulin (IG).

Because of the potential consequences of inadequately treated rabies exposure, precautions for immunosuppressed patients must be observed. Contraindications are few.

Corticosteroids, other immunosuppressive agents, antimalarials, and immunosuppressive illnesses can interfere with the development of active immunity and may predispose the patient to rabies. When PEP is administered to patients with these pre-existing conditions, serologic evidence of an acceptable antibody response is important.

Pregnancy is not considered a contraindication to postexposure prophylaxis.

Persons who have a history of serious hypersensitivity to rabies vaccine should be revaccinated with caution.

Acknowledgment is given to Jack K. Grigor, D.V.M., M.P.H., Chief, Center for Veterinary Public Health, Epidemiology and Disease Control Program, Maryland Department of Health and Mental Hygiene.

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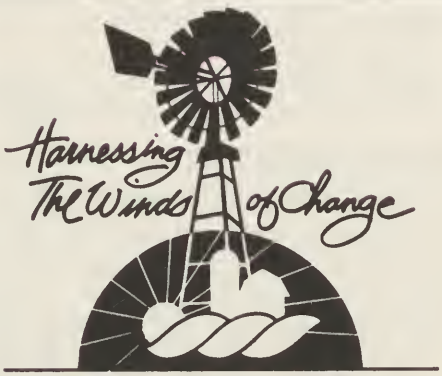
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Cite SEER

To determine if there is a correlation between heartburn and selected beverages, Feldman and Barnett (*Gastroenterology* 1995;108:125-131) measured the pH and total acidity of 38 common beverages. Study subjects had high heartburn scores after ingesting grapefruit, orange, V-8, and tomato juices, but low scores after drinking grape juice, Gatorade, and prune juice. Soft drinks, particularly Coca-Cola and Pepsi-Cola, were the most acidic beverages tested (pH 2.35), but were associated with only moderate heartburn scores. Although the pH of both red and white wines was in the intermediate range (3.52), both produced high heartburn scores. Coffee, with a high pH relative to other study beverages (5.14), produced a heartburn score and frequency of occurrence near the top of the list; tea, with a higher pH (5.80), produced a much lower score. **Medications used to treat heartburn are generally expensive. Lifestyle modifications may be a less costly way to initiate therapy for this extremely common gastrointestinal complaint.**

Although the incidence of myocardial infarction is much lower in young and middle-aged women than in men, menopause (naturally occurring or surgically induced) increases the risk of coronary disease threefold. In the elderly, cardiovascular disease is the leading cause of death in both men and women. Recently reported data from the ongoing Framingham Study (*Arch Intern Med* 1995;155:57-61) indicate that **high ratios of total/high-density lipoprotein cholesterol level ratios, left ventricular hypertrophy, and diabetes significantly increase the risk of coronary disease in women.**

A recently reported study involving 911 white men and women aged 40 and older confirms earlier reports that **cigarette smoking increases the risk of facial wrinkling** (*Am J Public Health* 1995;85:78-82). The authors conclude that, because this information may help convince people not to start smoking, it should be included in smoking prevention materials and programs.

Ulcerative colitis is a debilitating disease of elusive etiology that occurs primarily in young people but has a second peak during the sixth and seventh decades. Rutgeerts and coworkers (*Gastroenterology* 1994;106:1251-1253) reported a marked difference in prevalence, however, in patients with intact appendixes: **of 174 patients with ulcerative colitis, only 1 (0.6%) had had an appendectomy, whereas 41 of 161 control patients (25.4%) had undergone appendectomy ($p. < 0.001$).** Possible mechanisms to explain the observation remain conjectural, but the following hypothesis is proposed. The appendix is an important component of gut-associated lymphoid tissue, and its removal could change the balance of helper and suppressor T lymphocytes within the body and either promote or inhibit other etiological factors involved in the development of ulcerative colitis. Although no physician will want to prescribe "prophylactic" appendectomy, the association is worth watching for in daily practice.

Cite SEER

Data from the 1991 National Health Interview Survey (*Arch Fam Med* 1995;4:41-45) indicate that, **compared to urban residents, rural residents are less knowledgeable about human immunodeficiency virus and are less likely to have been tested for it.** Although both groups are at similarly high risk for contracting HIV, rural residents believe they are at low risk. Increased counseling and HIV testing may be warranted in rural areas.

Is the Whipple procedure associated with a high surgical complication rate and debilitating postoperative gastrointestinal symptoms? **Results of a study to determine quality of life and nutritional status of patients following a Whipple procedure indicate that these factors were not significantly different from those of control subjects.** Although GI symptoms did occur, they were usually mild. Even in diabetic patients, postprandial insulin responses were well maintained. The authors conclude that in patients with no recurrence of malignancy, functional changes due to the procedure are minimal and quality of life is excellent (*Am J Surg* 1995;169:179-185).

Parenthood may be hazardous to back health in men. Logistic regression analysis of a questionnaire survey completed by 129 fire fighters and 346 police officers showed that self-reported back pain was significantly associated with duration of employment, cigarette smoking, and number of children. Suggesting that this previously unreported factor may be associated with lifting children and recreational activities, the authors conclude that fatherhood may be a confounder that should be controlled for in studies of occupational causes of back pain (*Occup Environ Med* 1995;52:51-53).

Results of **a three-month observational study involving 1548 in-line skaters showed that almost one third failed to use protective gear.** Although wrist guards were used by 64.5% of skaters, helmets were worn by only 2.6%. Those least likely to use protective equipment were adolescent males, children, and advanced skaters (*Arch Fam Med* 1995;4:19-23).

Based on data indicating that patients consider their physicians to be an important source of health advice and that **even brief physician counseling may help patients modify unhealthy behavior,** the U.S. Preventive Services Task Force recommends that physicians give patients advice about quitting smoking, weight reduction, and exercise. A population-based telephone survey of Missouri residents, **however,** found that less than half were advised by their physicians about altering risk behaviors. **Of 535 smokers, only 42% were advised to quit; of 1246 sedentary patients, only 15% were told to exercise more; and of 521 patients who were overweight, only 43% were advised to lose weight** (*Am J Prev Med* 1994;10:367-371).

Naltrexone, the opiate antagonist recently approved by the U.S. Food and Drug Administration as an adjunct to psychosocial treatments for alcoholism, also has been reported useful in the treatment of self-injurious behavior and autism. In a recent study, 8 of 13 **autistic children aged 3.4 to 8.3 years showed modest improvement in behavior and social communication while taking naltrexone** 1.0 mg/kg/day. Although side effects were mild and transient, the tablet's bitter taste significantly affected compliance (*J Am Acad Child Adolesc Psychiatry* 1995;34:223-231).



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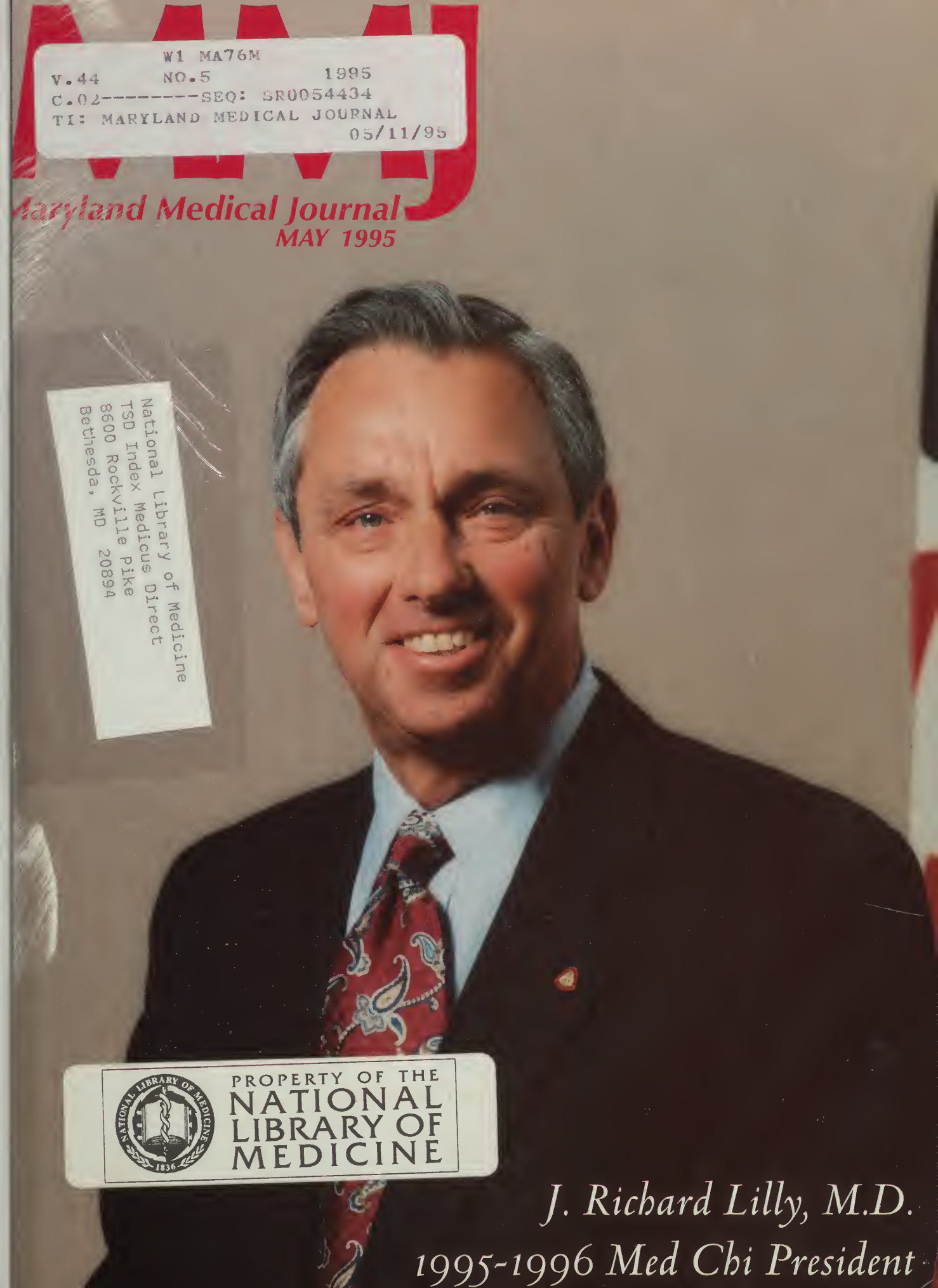
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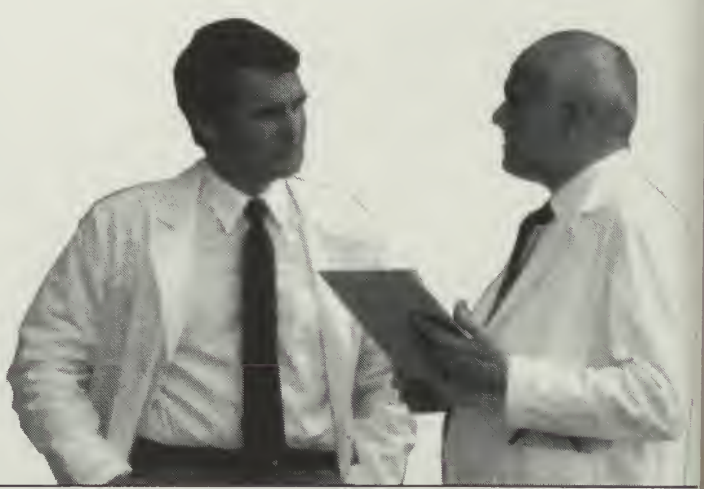
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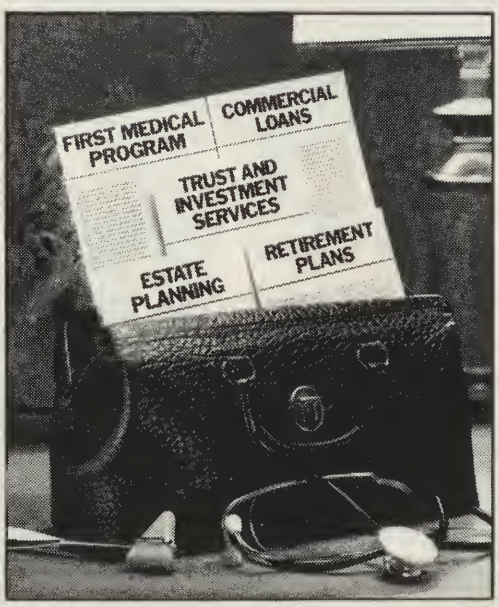
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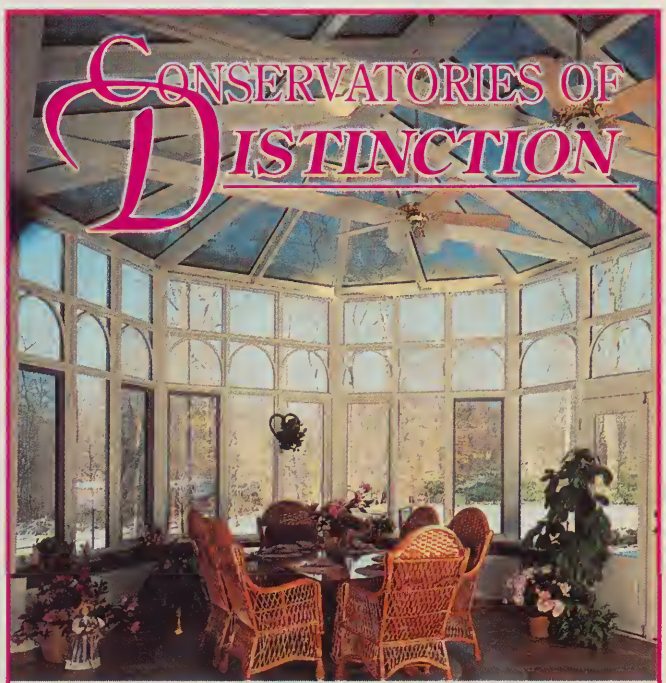
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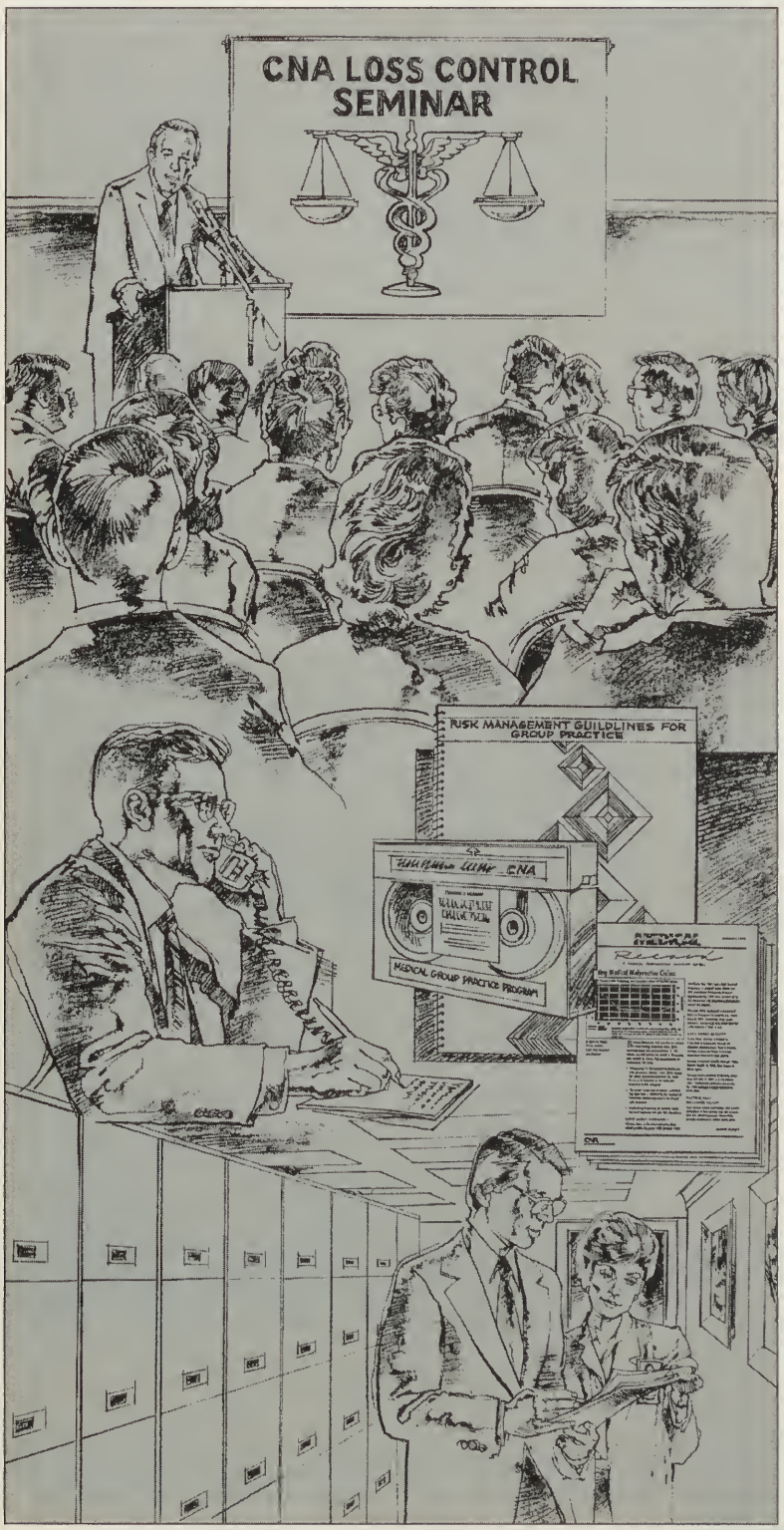
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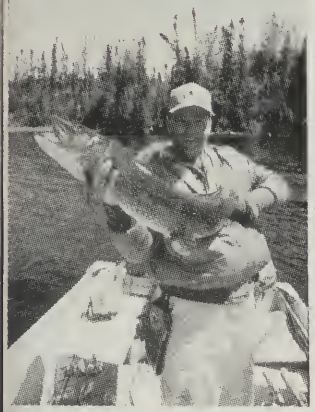
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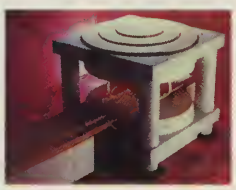
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Many physicians still make house calls, some enroute between home and office or the hospital, and others at specific times, i.e. Saturday mornings. Med Chi is currently in the process of identifying Maryland physicians who provide this service. If you make house calls for many or for a few of your patients, or know colleagues who do, please call Angelo Troisi, FACHE, ASAP, at 410-539-0872 or 1-800-492-1056. We will not publish this list, but need to show that many physicians in Maryland are patient oriented.

Study Group in Alternative Medicine

The next meeting of the Study Group in Alternative Medicine will be held on Wednesday, June 7 at 7:30 pm in the Krause Room at Med Chi. Dr. Teitelbaum will discuss his article "Effective Treatment of Chronic Fatigue Syndrome and Fibromyalgia," which will appear later this year in the *Journal of Musculoskeletal Pain*. Dr. Teitelbaum practices internal medicine in Annapolis.

Please call Steve Jones at Med Chi at 410-539-0872 or 1-800-492-1056, or Hiroshi Nakazawa, M.D., at 410-644-1502 if you wish to attend or have questions regarding the study group. Light refreshments will be served.

Evaluation and Management Documentation Guidelines

Between May 1, 1995, and July 1, 1995, Medicare carriers will begin a phase-in process for the documentation guidelines for evaluation and management services. The exact process has not been formalized and will depend, in part, on results of the educational process and comments received. Beginning August 1, 1995, evaluation and management codes will no longer be excluded from the Medicare medical review system. Carriers will vary in their own timetables for utilizing the guidelines in reviewing evaluation and management services.

Clinical Laboratory Improvement Amendments (CLIA) Information

The Commission on Office Laboratory Accreditation (COLA) in Silver Spring, Maryland (800-298-8044), is a private, nonprofit educational and accreditation program for physician office labs. To prepare labs for CLIA inspections, COLA has developed a 299-question, self-administered questionnaire. Furthermore, nearly 6,000 physician office labs have enrolled in COLA's accreditation program, which is recognized by the Health Care Financing Administration (HCFA). Sources indicate that COLA's inspections cost less than HCFA's inspections.

To obtain HCFA's CLIA inspection manuals, which include survey procedures and interpretive guidelines to help prepare for inspections, call the National Technical Information Service at 1-800-553-6847 and ask for PB92146174 and PB93950012.

The Medical Group Management Association (MGMA) provides "Directions: Quality Assurance Manual for Physician Office Laboratories." Call 303-397-7888 to obtain a copy.

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The next provider seminars will be held on May 9 and 23, 1995, at TrailBlazer Health Enterprises, 11130 Executive Plaza III, McCormick Road, 2nd Floor, Hunt Valley, MD 21031, 9:00 am - 3:30 pm.

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Medicare Supplier Information

OBRA 1993 authorized a phased-in extension of benefits from 12 to 36 months for coverage for immunosuppressive drugs ordered after a covered organ transplant. Over the next few years, the coverage for a particular beneficiary will be determined by the month of discharge following a Medicare-covered transplant.

Coverage for beneficiaries whose date of discharge from the hospital following a covered transplant was on or before July 31, 1993, is limited to one year. For transplants with hospital discharge dates of August 1, 1993, or later, the phase-in will be applicable.

For beneficiaries who are eligible for extended coverage, submitted claims that were denied may be resubmitted, or if a claim was not filed, an original bill for a previously unbilled month (1994 or 1995) may be submitted.

HealthPlus Physician Reimbursement Changes

HealthPlus plans to convert its physician reimbursement fee schedule to a Resource-Based Relative Value Scale (RBRVS) effective March 27, 1995. The RBRVS methodology will replace the present HealthPlus fee schedule for most specialist physicians who are not paid under capitation or other specially negotiated case rates or fees. HealthPlus will use Medicare relative value units and geographic modifiers with its own per-unit conversion factors.

The RBRVS system will be implemented over the next two to three years. According to HealthPlus, as a result of the implementation, almost all evaluation and management procedures (CPT codes 90201-99499) will receive increased reimbursement; some surgical procedures will receive increased reimbursement; and many surgical procedures will receive decreased reimbursement. HealthPlus will not, at this time, implement the RBRVS system for nonsurgical medical procedures (CPT codes 90700-99199). The overall result of the RBRVS system, according to HealthPlus, will be reimbursements that are approximately thirty percent (30%) higher than the 1995 Medicare fees for the applicable geographic area.

Participants Needed for Study of Paralyzed People

Physicians at the University of Maryland Medical Center, James Lawrence Kernan Hospital, and the Baltimore VA Medical Center are participating in a multi-center study of a new type of technology that uses electrical stimulation to enable paralyzed people who cannot use their hands to grasp and release objects. Additional participants for the study are currently being recruited. Potential candidates have quadriplegic spinal cord injuries, are able to move their shoulders and elbows, and have completed a standard rehabilitation program. For additional information, call Linda Marshall at 410-605-7171.

National Database on Pancreatic Cancer

Researchers at The Johns Hopkins Medical Institutions are assembling what is believed to be the first national database on pancreatic cancer patients and their families. The National Familial Pancreas Tumor Registry will help scientists learn if pancreatic cancer runs in families, and if so, determine the patterns of inheritance. To register, a patient, family member, or physician should contact Medhat Osman, M.D., or Amanda Lietman, R.N., at 410-955-9132 or 410-614-3405. The registry will send a detailed questionnaire and requests for tissue samples to the patient and family.

NIH Consensus Development Conference on Cochlear Implants

An NIH Consensus Development Conference on cochlear implants in children and adults is scheduled for May 15–17, 1995, at the Natcher Conference Center, National Institutes of Health, Bethesda, Maryland. Sponsored by the National Institute on Deafness and Other Communication Disorders and the NIH Office of Medical Applications of Research, the conference is open to the public. During the first two days, experts in cochlear implantation and other relevant fields will present current scientific thinking and concerned voluntary organizations will be invited to make statements. On the third day, the consensus panel will present its draft report and invite comments from the audience. To register for the conference or to obtain additional information, contact Conference Registrar,

Technical Resources International, Inc., 3202 Tower Oaks Blvd., Rockville, MD 20852; tel: 301-770-0610; fax: 301-468-2245.

HCFA Launches Medicare Mammography Campaign

The Health Care Financing Administration (HCFA) will launch a consumer and provider awareness campaign this spring to promote awareness of Medicare's mammography benefits. Screening mammograms became a Medicare-covered benefit on January 1, 1991.

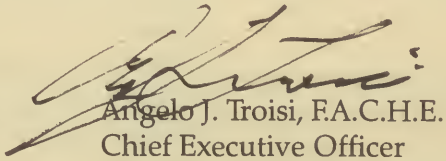
Despite the high incidence and mortality of breast cancer among elderly women, recent Medicare claims analyses indicate that fewer than 7 million (less than 40%) of 18 million female Medicare beneficiaries age 65 or older received a diagnostic or screening mammogram during the past two years. The Department of Health and Human Services Year 2000 Goal is to increase the number of older women who receive screening mammograms every 24 months to 60% of the eligible population. The HCFA campaign will include a brochure that will describe the Medicare mammography benefit and urge women to seek mammograms through their health care provider or other local organizations.

If you would like more information about this HCFA initiative or would be interested in working on the campaign, contact Monnie M. McAdoo at 215-596-0586.

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1995 Component Society Presidents



Allegany County

WAYNE C. SPIGGLE, M.D., is the current president of the Allegany County Medical Society. He received his medical degree from the Medical College of Virginia and completed a rotating residency at the Charleston Memorial Hospital in Charleston, West Virginia. In addition he completed a residency in internal medicine at the West Virginia University Medical Center. Dr. Spiggle is a founding associate of the Braddock Medical Group and an attending physician at Sacred Heart and Memorial hospitals and Lions Manor Nursing Home in Cumberland, Maryland. A member of the American Society of Internal Medicine and Alpha Omega Alpha Honorary Medical Society, Dr. Spiggle is co-chair of the Chamber of Commerce Medical Liaison Committee and a board member of the Center for Environmental and Estuarian studies. He is the recipient of many honors and awards, including the Wyeth Ayerst Laboratories Physician Award for Community Service, the American Society of Internal Medicine Community Service Award and the Common Cause of West Virginia Community Service Award. In addition to practicing medicine, Dr. Spiggle's interests include small farm and woodlot management, sustainable agriculture, golf, fishing, and gardening.



Anne Arundel County

MARGARET M. MULLINS, M.D., an internal medicine specialist and an acupuncturist in private practice in Cape St. Claire, Maryland, is the first woman to serve as president of the Anne Arundel County Medical Society. A native of Wisconsin, Dr. Mullins received her medical degree from the Medical College of Pennsylvania. She completed an intership in internal medicine in the social medicine department at Montefiore, Bronx, New York, and an internship in general surgery at Mayday Hospital, Croydon, England. She finished her residency training in internal medicine at Lankeuau Hospital. In addition, Dr. Mullins received her licentiate in acupuncture from the College of Traditional Chinese Acupuncture in the United Kingdom. Board eligible in emergency medicine, Dr. Mullins is a national boards diplomate, an internal medicine diplomate, and a diplomate of the National Commission for Certification of Acupuncturists. A founding member of the American Academy of Medical Acupuncturists, she is very active in several professional organizations, including the American Medical Women's Association.



Baltimore City

WILLARDA V. EDWARDS, M.D., an internist in Baltimore, was installed as president of the Baltimore City Medical Society in December 1994. A graduate of the University of Maryland School of Medicine, Dr. Edwards completed her internship and residency at Greater Baltimore Medical Center. In addition to her private practice, Dr. Edwards holds the rank of commander in the Navy Reserves. She has staff privileges with Church, Bon Secours, Bayview and Franklin Square hospitals, as well as Liberty Medical Center. A member of many scientific and professional societies, Dr. Edwards has served on the board for Big Brothers and Big Sisters of Central Maryland and the alumni board of the University of Maryland School of Medicine. She is the incoming president of the Monumental City Medical Society and will serve as president of both city medical societies concurrently this year. In addition, she has served on the board of the National Medical Association and serves as vice chairperson of the association's Region II and treasurer of its Maryland State Medical Association. She has served as a member of the Expansion of Insurance Reform Task Force and has governor's appointments as commissioner of both the Maryland High Blood Pressure Commission and the Health Services and Cost Review Commission.



Baltimore County

MAYER C. LIEBMAN, M.D., president of the Baltimore County Medical Association, earned an A.B. in biological sciences and did graduate work in biochemistry at The Johns Hopkins University. After receiving his medical degree from the New York University, he completed his internship at Kings County Hospital in Brooklyn, New York, and his residency at Bellevue Psychiatric Hospital in New York City. Following medical training, Dr. Liebman served his military obligation at the National Institute of Mental Health, U.S. Public Health Service, from 1966 to 1968 in Washington, DC. In 1968, he joined the staff of the Sheppard & Enoch Pratt Hospital in Towson, Maryland. While there, he developed and directed the Northern Baltimore County Community Mental Health Center and was the hospital's first director of admissions. In 1978, he graduated from the Baltimore-Washington Institute of Psychoanalysis and in 1979, was certified in mental health administration. Dr. Liebman went into full-time practice of general psychiatry and psychoanalysis in 1981. He is an associate on the courtesy staff in the department of psychiatry at Greater Baltimore Medical Center, a preceptor member on the medical staff at Sinai Hospital, and a member of the psychiatric staff at Saint Joseph Hospital and the courtesy staff at Sheppard Pratt. Certified in psychiatry by the American Board of Psychiatry and Neurology, Dr. Liebman is a fellow of the American Psychiatric Association and the International Association of Social Psychiatry. He is active in the Maryland Psychiatric Society and the American Psychoanalytic Association and is a member of Med Chi's House of Delegates and Legislative Committee. He has been involved in the Beth Tfiloh Congregation, Hebrew Immigrant Aid Society, and Associated Jewish Charities.



Calvert County

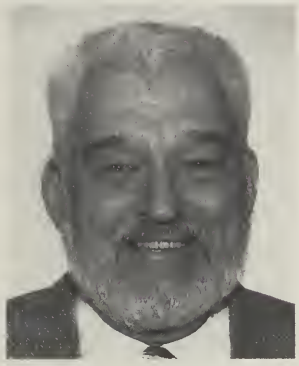
GERALD P. STERNER, M.D., is the president of the Calvert County Medical Society. A graduate of the University of Maryland School of Medicine, Dr. Sterner completed his residency in family practice, and served as chief resident at the University of Maryland Hospital. He is currently a family practitioner in Owings, Maryland, and serves as president of the corporation Sterner & Umhau M.D.S. Chartered. A diplomate of the American Board of Family Practice and the National Board of Medical Examiners, Dr. Sterner holds continous admitting hospital privileges at the Calvert Memorial Hospital in Prince Frederick, Maryland. He is past vice president of the medical staff at Calvert Memorial Hospital and was honored with the Physician's Recognition Award for community service. A member of the American Academy of Family Physicians and the Maryland Academy of Family Physicians, Dr. Sterner is a charter board member of the Calvert Memorial Hospital Foundation. He serves as a mentor for life sciences-medically oriented students at Calvert County Senior High School and Northern Senior High School.



Caroline County

CHRISTIAN E. JENSEN, M.D., M.P.H., has been president of the Caroline County Medical Society since 1979. Dr. Jensen received bachelor's and master's degrees from Rutgers University. He graduated from Duke University Medical School and earned his master's degree in public health from the Medical College of Wisconsin. He completed an internship at the Naval Hospital in Portsmouth, Virginia, and a residency in occupational medicine at the University of Cincinnati College of Medicine. He is board certified in family practice and preventive medicine in occupational medicine. A Naval Reserve captain, Dr. Jensen is a Vietnam and Desert Storm veteran. In addition to his

private practice, he has been medical director of the Delmarva Foundation since 1990. Dr. Jensen is a member of the American Medical Association, the Delaware State Medical Society, and the Naval Reserve Association. He is a fellow of the American Academy of Family Practice and holds master status in the American College of Occupational Medicine. Dr. Jensen is author of the book *Physicians of Caroline County Maryland 1774-1984.* He farms 500 acres in Caroline County.



Carroll County

RICHARD ARVIN JONES, M.D., is the current president of the Carroll County Medical Society. He received his undergraduate degree from Bridgewater College, Bridgewater, Virginia, and his medical degree from the University of Maryland School of Medicine, Baltimore. Dr. Jones did a rotating internship at Mercy Hospital and a medical residency in pathology at the University of Maryland School of Medicine. Dr. Jones served in the United States Air Force as chief of flight surgeons. He completed a three-year residency at the United States Public Health (USPH) Hospital in Baltimore, before going to the USPH Hospital in Staten Island, New York, where he served as assistant and deputy chief of pathology. He is currently the director of the laboratory and chief of pathology at Carroll County General Hospital and is deputy medical examiner. He is a member of the American Society of Clinical Pathologists, College of American Pathology, and Maryland Society of Pathologists.



Cecil County

HENRY FARKAS, M.D., M.P.H., began his tenth term as president of the Cecil County Medical Society in January 1995. A native of New York City, Dr. Farkas attended Loyola College and The Johns Hopkins University, where he received his medical degree in 1970 and his master's degree in public health in 1971. After completing his internship at Lancaster General Hospital in Lancaster, Pennsylvania, Dr. Farkas served as general medical officer on a Navajo reservation in Chinle, Arizona. Returning to Maryland in 1973, he worked as an emergency physician at Harford Memorial Hospital and as medical director of the Cecil County Detention Center. Currently, Dr. Farkas practices emergency medicine at Union Hospital of Cecil County, where he has held the posts of president of the medical staff, chairperson of the emergency department, and medical director of occupational health. He also serves as medical director of the Northern Chesapeake Hospice and the Medical Adult Day Care Center of Union Hospital of Cecil County. An active member of Med Chi, Dr. Farkas serves on the Peer Review Committee. He is a member and sits on the board of directors of the Maryland chapter of the American College of Emergency Physicians.



Charles County

WHEI-RUNG FU, M.D., is the current president of the Charles County Medical Society. Dr. Fu received his professional education at the National Taiwan University College of Medicine, Taipei. He completed an internship at Bryan Memorial Hospital, Lincoln, Nebraska. He completed residencies in radiology at Bexar County Hospital, University of Texas Medical School, San Antonio, and University of Pennsylvania Graduate Hospital in Philadelphia, where he also did a fellowship in cardiovascular radiology. Board certified in radiology, Dr. Fu is currently attending radiologist and chairman of the department of

radiology at Physicians Memorial Hospital in La Plata, Maryland. He is also clinical associate professor of radiology at Georgetown University, Georgetown University Hospital, in Washington, DC.

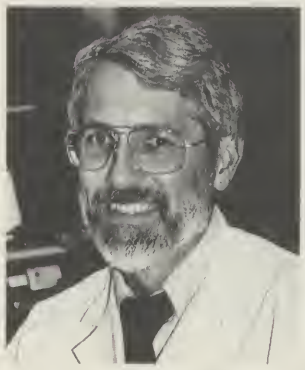


Dorchester County

M. WALID KAMSHEH, M.D., is president of the Dorchester County Medical Society. Dr. Kamsheh received his medical degree from the Maussat Women and Children's Hospital School of Medicine in Damascus, Syria, and completed his residency training in the department of neurology at the Medical College of Virginia, McGuire VA Hospital in Richmond, Virginia. Board eligible in neurology, Dr. Kamsheh is the former chief of medicine at Dorchester General Hospital. He is currently in private practice with an office in Cambridge, Maryland. He has hospital privileges with the Eastern Shore Hospital Center and Easton Memorial and Dorchester General hospitals. In addition, he is an associate professor in the department of neurology at the University of Maryland in Baltimore. A delegate to Med Chi, Dr. Kamsheh is active in several medical and professional organizations.

Frederick County

JOHN VITARELLO, M.D., president of the Frederick County Medical Society, received his medical degree from the University of Maryland School of Medicine, where he also was granted a cardiovascular fellowship. He completed his internship at Maryland General Hospital and residency training at the University of Maryland Hospital. Currently, Dr. Vitarello has a private practice in Frederick, Maryland, specializing in cardiovascular diseases. In addition to his private practice, he is an active staff member at Frederick Memorial Hospital. Board certified in internal medicine and cardiology, Dr. Vitarello is a member of the American College of Cardiology and the American College of Chest Physicians.



Garrett County

THOMAS G. JOHNSON, M.D., is the current president of the Garrett County Medical Society. He received his bachelor's degree from Pennsylvania State University and his medical degree from the University of Pittsburgh. He completed a rotating internship at Roanoke Memorial Hospital. Dr. Johnson is currently chief of staff and director of the coronary intensive care unit and cardiopulmonary department at Garrett County Memorial Hospital. He is president of the Garrett Medical Group, P.A., and has a full-time family practice in Oakland, Maryland. He also is clinical assistant professor at the University of Maryland department of family medicine and assistant clinical instructor at George Washington University. Dr. Johnson is a member of the American Academy of Family Physicians and American Medical Association.



Harford County

BRAD COGAN, M.D., is president of the Harford County Medical Society. Dr. Cogan holds degrees from Colgate University and the Boston University School of Medicine. After completing his internship and residency at the Medical University of South Carolina, Dr. Cogan became an associate professor in the department of radiology at the University of South Alabama in 1979. He served as assistant professor of diagnostic radiology at the University of Texas System Cancer Center from 1981 to 1984, and as chief of radiology at Harford Memorial Hospital from 1984 to 1991. Currently, he works in radiology at the Howard County General Hospital in Columbia, Maryland. A diplomate of the National Board of Medical Examiners, Dr. Cogan is a member of several professional organizations. He is a native of New York.



Howard County

RUSSELL O. SCHUB, M.D., is president of the Howard County Medical Society. Dr. Schub earned his medical degree from the New York College of Osteopathic Medicine of the New York Institute of Technology and completed his internship and residency training in the department of internal medicine at the Coney Island Hospital/Downstate Medical Center in New York. Following his residency training, he was a fellow at The Johns Hopkins University School of Medicine and its medical institutions in Baltimore. Certified by the American Board of Internal Medicine and the American Board of Internal Medicine: Gastroenterology, Dr. Schub holds staff positions at Montgomery General, Saint Agnes, and Howard County General hospitals. He is a fellow of the American College of Physicians and a member of several professional organizations. He has published a number of scientific articles.



Kent County

ANTHONY J. MOORMAN, M.D., a native of Kentucky, is president of the Kent County Medical Society. Dr. Moorman received his medical degree from the Medical College of Virginia in Richmond. He completed his internship and residency training in the obstetrics and gynecology department of the Tripler Army Medical Center in Honolulu, Hawaii. A junior fellow of the American College of Obstetricians and Gynecologists, Dr. Moorman is a member of the Society of Laparoendoscopic Surgeons and the Southern Medical Association. Certified by the National Board of Medical Examiners and the American Board of Obstetrics and Gynecology, Dr. Moorman is currently an attending physician in the department of obstetrics and gynecology at the Kent & Queen Anne's Hospital in Chestertown, Maryland.



Montgomery County

MARK S. SEIGEL, M.D., is the president of the Montgomery County Medical Society. Dr. Seigel was the first student to be awarded a B.S. degree in computer science and engineering from the University of Pennsylvania Moore School of Electrical Engineering. He received his medical degree from the University of Pennsylvania School of Medicine and completed a residency in obstetrics and gynecology at the State University of New York at Buffalo. Currently, Dr. Seigel is in the private practice of obstetrics and gynecology in Gaithersburg, Maryland. As former chairperson of the department of obstetrics and gynecology at Shady Grove Hospital, Dr. Seigel worked with Dr. Martin Wasserman and the Montgomery County Health Department on "Project Deliver," which brought obstetric coverage to indigent patients while giving physicians liability protection. Very active in Med Chi, Dr. Seigel has been a member of several committees, including Computers in Medicine and Rules and Regulations. In addition to practicing medicine, Dr. Seigel enjoys skiing, computers in medicine, and figure skating.



Prince George's County

SAID A. DAEE, M.D., has been named the 91st president of the Prince George's County Medical Society. A graduate of the Jundi Shapour University Medical School in Ahwaz, Iran, Dr. Daee served as acting flight surgeon in the Royal Iranian Air Force until 1973. Following his military service, he completed his surgical residency training at Prince George's Hospital Center and currently maintains a private surgical practice with offices in Greenbelt, Bladensburg, and Rockville, Maryland. A fellow of the American College of Surgeons, Dr. Daee is an attending trauma physician at Prince George's and Suburban hospitals and an attending physician at Doctors' Community and Holy Cross hospitals and Washington Hospital Center. In addition, he is president

of the International College of Surgeons, U.S. Section, and an advanced trauma life support instructor at several hospitals in the metropolitan area.



St. Mary's County

M.F.O. LAFEER, M.D., is the president of the St. Mary's County Medical Society. Dr. Lafeer earned his medical degree from the Faculty of Medicine at the University of Ceylon in Colombo, Sri Lanka. He completed a surgical and pediatric internship at the General Hospital in Colombo, Sri Lanka, a rotating internship at St. Joseph's Hospital in Lorain, Ohio, and a pediatric residency at the D.C. General Hospital in Washington, D.C. A fellow of the American Academy of Pediatrics and a diplomate of the American Board of Pediatrics and the American Board of Quality Assurance and Utilization Review Physicians, Dr. Lafeer is in the private practice of pediatrics with Shah Associates M.D., P.A. in Leonardtown, Maryland. As the former chief of the medical staff at St. Mary's Hospital in Leonardtown, Dr. Lafeer has active privileges in the department of pediatrics and is a member of the Executive Credential/Quality Assurance Committee of the Medical Staff at the hospital. In addition, he is director of quality assurance for the Tri-County Endoscopy Center in Leonardtown and the director of quality assurance and laboratories for Shah Associates, M.D., P.A.



Somerset County

JAMES A. STERLING, M.D., is the current president of Somerset County Medical Society. Dr. Sterling received his bachelor's degree from Williams College, Williamstown, Massachusetts, and his medical degree from George Washington University. He completed his internship and residency at Baltimore City Hospital and served in the United States Navy. Since 1967, Dr. Sterling has maintained a family practice in Crisfield, Maryland, the town where he was born. He is on the staff of McCready Memorial Hospital and is currently the medical director and deputy coroner for Somerset County.



Talbot County

MICHAEL J. FISHER, M.D., has been elected president of the Talbot County Medical Society. A graduate of the University of Maryland School of Medicine, Dr. Fisher completed his internship and residency in internal medicine at Mercy Hospital in Baltimore, Maryland. In addition, he was a gastroenterology fellow at the University of Virginia Hospital in Charlottesville. A fellow of the American College of Gastroenterology and a diplomate of the American Board of Internal Medicine and the American Board of Internal Medicine: Gastroenterology, Dr. Fisher has written numerous scientific articles. He is currently an attending physician at Memorial Hospital in Easton, Maryland.



Washington County

EDWARD W. LAMPTON, JR., M.D., has been president of the Washington County Medical Society since 1993. A native of West Virginia, Dr. Lampton graduated from West Virginia University and the University of Maryland School of Medicine, where he was a member of the Alpha Omega Alpha honorary fraternity. He completed his internship at the University of Pittsburgh Children's Hospital and his residency training at the University of Maryland Hospital in diagnostic radiology. He is a fellow of the American College of Radiology, serving on the Government Relations Committee of General and Pediatric Radiology. Dr. Lampton is a member of the American Medical Association, Radiological Society of North America, American Institute of Ultrasound in Medicine, Society of Breast Imaging, and Society of Ultrasound in Medicine. He is legislative chairperson and a member of the board of the Maryland Radiological Society. Board certified in radiology, Dr. Lampton currently is a staff

radiologist for Associated Radiologists, P.A., in Hagerstown. He is an active member of Med Chi, serving on the Legislative Committee.



Wicomico County

CHRISTJON J. HUDDLESTON, M.D., is president of Wicomico County Medical Society. He is a graduate of the University of Maryland School of Medicine and completed his residency training in the department of internal medicine at Union Memorial Hospital in Baltimore. Board eligible in internal medicine, Dr. Huddleston is an instructor of clinical medicine I and II in the department of physical therapy at the University of Maryland, Eastern Shore, and the medical director of the University of Maryland, Eastern Shore Student Health Center. In addition, he has hospital privileges with Peninsula Regional Medical Center in Salisbury. Dr. Huddleston is a native of California.

Worcester County

STEVEN F. WATERS, M.D., began his sixth term as president of the Worcester County Medical Society in January 1995. Dr. Waters holds degrees from Catholic University with honors and from the Georgetown University School of Medicine. After completing a family practice residency at Franklin Square Hospital in Baltimore in 1983, Dr. Waters began his private practice in family and ambulatory medicine in Ocean City. A diplomate of the National Board of Medical Examiners, Dr. Waters is a member of the American Medical Association, American Academy of Family Practice, and Maryland Academy of Family Practice. Dr. Waters is a native of Pennsylvania.



Resident Component

MARIA ESTELA SIMBRA, M.D., became the president of the Maryland Medical and Chirurgical Resident Society in May 1994. She received her bachelor's degree in chemistry and biology from West Virginia University, Morgantown, and then attended the University of Pittsburgh School of Medicine. She is currently a resident at the Georgetown University Medical Center in Washington, DC. Dr. Simbra also went to the Betty Ford Center Medical Student Professional-in-Residence Summer School Program, Rancho Mirage, California, and the American Society of Pathologists' Post-Sophomore Medical Student Fellowship in Pathology, Pittsburgh, Pennsylvania. She is a member of the American Medical Association Resident Section.

Med Chi would also like to recognize component society presidents whose biographical information was not available at press time:

Queen Anne's County



Student Component Society: KELLY GEBO

Erratum

In the March issue (*Md Med J* 1995;44:190), one of Dr. Melvin L. Keller's faculty positions was listed incorrectly and one was omitted. Dr. Keller is a clinical associate professor of anesthesiology at the University of Maryland School of Medicine and an assistant professor of anesthesiology/critical care medicine at The Johns Hopkins University School of Medicine.

Matthew R. Weir, M.D., a nephrologist in the department of medicine at University of Maryland Hospital in Baltimore, is co-author of a literature review of long-term clinical trials that have evaluated the impact of converting enzyme inhibitors, nondihydropyridine calcium antagonists, and other drugs on the progression of diabetic renal disease. The review, which focuses on renal effects of antihypertensive agents independent of blood pressure reduction, was published in the *Journal of Clinical Pharmacology* (1994;35:73-80).

Walker L. Robinson, M.D., a neurosurgeon, and **Gary D. Hack, D.D.S.**, a professor of dentistry, both of the University of Maryland at Baltimore, have discovered a previously unknown anatomical relationship: connective tissue that links the rectus capitis posterior minor muscle with the dura mater. Drs. Robinson and Hack presented their findings in February at a joint meeting of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons held in Phoenix, Arizona.

Charles E. Wiles, III, M.D., is co-author of a study published in *Critical Care Medicine* (1994;22:1796-1804) that found trauma and septic patients are hypermetabolic, even when heavily sedated or medically paralyzed. Dr. Wiles is director of the multiple trauma intensive care unit at the R Adams Cowley Shock Trauma Center in Baltimore.

Alan W. Partin, M.D., Ph.D., of the department of urology at The Johns Hopkins Hospital, is the lead author of the first reported study of the incidence of benign prostatic hyperplasia among twins. Results, indicating the disorder may be heritable, were published in *Urology* (1994;44:646-650).

Shalom Kelman, M.D., director of neuro-ophthalmology at the University of Maryland School of Medicine, is a principal investigator and the chairperson of a multicenter study indicating that optic nerve decompression, a surgical procedure to restore sight in patients with nonarteritic anterior ischemic optic neuropathy, may in fact make vision worse. Results of the study were published in *JAMA* (1995;273:625-632).

Wendy K. Bernstein, M.D., of the department of medicine at Sinai Hospital of Baltimore, is the lead author of a study that found magnesium is not effective as a bronchodilator in chronic, stable asthma (*Arch Intern Med* 1995;155:271-276). Other Sinai physicians involved in the study are Anupa Khastgir, M.D., Steven A. Schonfeld, M.D., Jack E. Nissim, M.D., and Bart Chernow, M.D.

Henry Brem, M.D., 1995 recipient of the Society for Biomaterials' Clemson Award for Applied Research, presented results of his research on polymeric drug delivery to the brain at the society's annual meeting in San Francisco in March. Dr. Brem is a professor of neurosurgery, ophthalmology, and oncology at The Johns Hopkins University School of Medicine and director of neurosurgical oncology at Hopkins Hospital.

David Sidransky, M.D., associate professor of otolaryngology and oncology at The Johns Hopkins University School of Medicine, and other Hopkins researchers have conducted two studies involving the p53 gene recently published in the *New England Journal of Medicine*. One report (1995;332:429-435) describes molecular assessemnt of histopathological staging in squamous-cell head and neck cancer. The second study (1995;332:712-717) found that smokers are twice as likely as nonsmokers to have mutations of the p53 gene.

William R. Kanter, M.D., a clinical instructor in plastic surgery at The Johns Hopkins University School of Medicine and staff member at Howard County General Hospital and St. Agnes Hospital in Baltimore, is one of the editors of *Aesthetic Blepharoplasty*, published last November by Little, Brown and Company. Other Maryland physicians who contributed chapters to the book are Sharon C. Gross, M.D., Ph.D., and Mitchel A. Kanter, M.D.

Peter Rowe, M.D., associate professor and general pediatrician at the Johns Hopkins Children's Center, is the lead author of a report published in *Lancet* (1995;345:623-624) indicating that neurally mediated hypotension may be associated with debilitating, chronic fatigue in teenagers. Among Dr. Rowe's coauthors are Hopkins physicians Hugh Calkins, M.D., Jean Kan, M.D., Issam Bou-Holaigah, M.D.

Victor A. McKusick, M.D., professor of medical genetics, biology, and epidemiology, and director of medical genetics at The Johns Hopkins University School of Medicine, is the editor of the eleventh edition of the two-volume, 3009-page work *Mendelian Inheritance in Man: A Catalog of Human Genes and Genetic Disorders*. The book was published by Johns Hopkins University Press in 1994.

Steven M. Frank, M.D., assistant professor of anesthesiology and critical care medicine at The Johns Hopkins Medical Institutions, is the lead author of study published in *Anesthesiology* (1995;82:83-93) investigating factors that may be associated with perioperative hypothermia. Other Hopkins physicians involved in the study are Michael J. Breslow, M.D., and Lee A. Fleisher, M.D.

David S. Cooper, M.D., director of endocrinology at Sinai Hospital of Baltimore, and **Paul W. Ladenson, M.D.,** were among nine experts selected by the American Thyroid Association to develop minimum clinical treatment guidelines for patients with hyperthyroidism and hypothyroidism. The group's recommendations were published in *JAMA* (1995;273:808-812). Drs. Cooper and Ladenson are associate professors of medicine in the division of endocrinology at The Johns Hopkins University School of Medicine.

Albert W. Wu, M.D., M.P.H., of the Health Services Research and Development Center at The Johns Hopkins University, is the lead author of a report describing a prognostic model designed to estimate the probability of severe functional limitations in adults two months after being hospitalized with serious illness. Results of the prospective cohort study were published in *Annals of Internal Medicine* (1995;122:342-350).

Health Commissioner **Peter Beilenson, M.D., M.P.H.,** is the lead author of a report describing the Baltimore City Health Department's experience with providing the contraceptive Norplant at a school-based health center (*Am J Public Health* 1995;85:309-311).

Judd W. Moul, M.D., F.A.C.S., associate professor of surgery at the Uniformed Services University of the Health Sciences, is the principal investigator of a study that found prostate-specific antigen and cancer volume are higher in black men with prostate cancer. Results of the study, which compared 632 black and white prostate cancer patients treated in the U.S. military health care system, were presented in March at the 86th annual meeting of the American Association for Cancer Research, held in Toronto.

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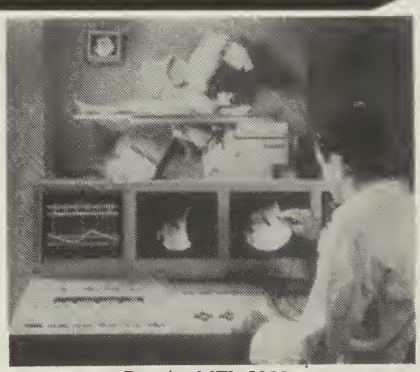


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Speak Out

Now that we can, should we? Investigating the wisdom of home HIV testing

Since the human immunodeficiency virus (HIV) began making medical headlines in the early 1980s, the public's curiosity about the disease has grown steadily. In slightly more than 10 years, the disease has progressed from being a medical mystery to being known as a fatal condition—one that individuals may soon be able to test for in the privacy of their own homes. Like many other wonders of modern medical science, it seems that more time was spent in the advancement of the testing technologies than in answering the question of whether home testing for HIV is a good idea.

The development of the initial laboratory test(s) for the presence of HIV was widely regarded as a major medical victory due to the high level of accuracy exhibited by these tests. Less than half a decade later, with the apparent success of the antiretroviral drug zidovudine (AZT), the emphasis shifted toward developing home testing kits. The rationale behind the wave of technologic optimism was that an individual could obtain a convenient, highly accurate test result that would allow for early and effective treatment. Another assumed benefit was that the HIV testing itself would slow the transmission of the virus.

There are a few difficulties with the lines of reasoning listed above. First, recent data published in the *Journal of the American Medical Association* indicate that the "earlier use [of AZT] in asymptomatic disease was not associated with an additional prolongation of survival compared with delayed initiation."[1] If so, the value of early screening to identify those in need of treatment may be much less than was originally thought. Second, the accuracy of a simplified version of the two-step laboratory test for HIV may prove to be less than expected. Even the highly regarded first-line laboratory immunoassays for HIV displayed frightening inconsistencies when first introduced. For example, among

Speak Out

random blood donors who tested positive for HIV (0.2 - 2.5%), only one in four remained positive when retested with the same kit. In addition, among the 25% who remained positive when retested, only 30% were positive for HIV when examined with confirmatory tests. In the final analysis of the early laboratory immunoassays, only 10% to 15% of the initial positive results were confirmed positive.[2,3] Third, the assumption that HIV testing slows viral transmission would have to be based on objective data before this supporting claim could be made.

Recent comprehensive reviews suggest there is insufficient evidence to encourage more widespread testing as a form of prevention.[4,5] As pointed out by Sackett and Holland,[6] the objective of screening is: "the early detection of diseases or conditions whose treatment is either easier or more effective when undertaken at an earlier point in time. There is thus an implicit promise that those who volunteer to be screened will benefit . . . and will receive treatments of proven efficacy." Neither are the current treatments for HIV infection efficacious nor is there an implicit promise of benefit with treatment. When the U.S. Food and Drug Administration altered its policy regarding review of home testing kits in 1990, one of the foremost reasons given was the presence of an "effective" treatment. According to Paul Parkman, director of the FDA's center for biologics, "the FDA has softened its stance against home testing because anybody testing positive can usefully be treated with AZT."[7]

Another controversial issue is the availability of counseling. According to Jean McGuire, executive director of the U.S. AIDS Action Council, "the biggest challenge posed by home testing is not the threat of inaccurate results or a breach of confidentiality, but the problem of counseling."[7] It has also been pointed out that not only is there an increased incidence of suicide in individuals testing positive, but that an individual test is almost a surrogate test for the person's partner and, possibly, children. The availability of professional counseling, therefore, has emerged as one of the key elements in initiating any campaign for widespread HIV testing.

Even if all the many complicated issues of the testing procedure itself were to be solved, ample evidence suggests that some individuals who are the most vulnerable to HIV infection are unwilling to undergo testing. In a state where premarital HIV testing was made compulsory, a large proportion of the resident couples got married elsewhere.[8] Anecdotal evidence from urban hospitals around the country indicates that many "high risk" people are unwilling to be tested. It seems very unlikely that a home test will change established behavior patterns.

Speak Out

The concept of re-evaluating certain testing protocols is not new. The British Department of Health, for example, banned HIV testing kits, citing the lack of definitive research data and inadequate counseling resources.[9]

We will soon be at a crossroads where the capability to test for certain conditions may exceed the wisdom of doing so. The capability to do something does not necessarily mean that it should be done. In the future, much of the determination for which procedures are done will rest with individual patients, who will choose what course of action they deem best. With that kind of control over their own welfare, a greater portion of the responsibility for the repercussions of such decisions will also rest with individual patients. It is increasingly apparent that the time has come to concentrate as much on the *whys* of medicine as on the *hows*.

DOUGLAS P. BEALL, M.D., AND JOHN J. WHYTE, M.D.
Dr. Beall is a radiology resident at The Johns Hopkins Hospital in Baltimore, Maryland. Dr. Whyte is an internal medicine resident at Duke University Hospital in Durham, North Carolina.

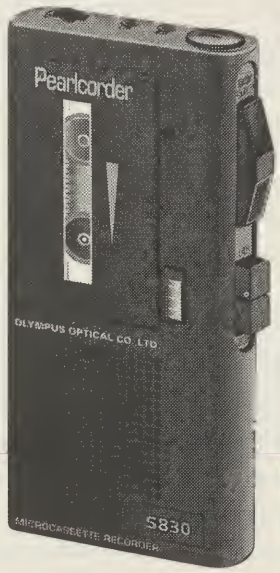
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AIR FORCE

J. Richard Lilly, M.D.: 1995-1996 president, Medical and Chirurgical Faculty of Maryland

Vivian Smith

Ms. Smith is the assistant director of communications for the Medical and Chirurgical Faculty of Maryland.

Many photographs adorn the walls and bookshelves of Dr. J. Richard Lilly's Hyattsville office—his family, Dr. Lilly with President Clinton and Representative Steny Hoyer, Dr. Lilly with Governor and Mrs. Glendening—but one best portrays his motivation as a primary care physician. On the credenza behind his desk sits a framed, black and white photograph of Dr. Lilly in a meeting with then-Governor Marvin Mandel, Edward Kowalewski, M.D., and the late Aris T. Allen, M.D. The photograph was taken when the physicians met with the governor to establish departmental status for family practice at the University of Maryland School of Medicine.

"One of my compelling, driving goals in the late 1960s and early 1970s was to raise the status of primary care physicians to that of specialty recognition," explains Dr. Lilly. "Primary care physicians were held in relatively low esteem, there were no departments of family practice in medical schools, and there were no departments of family practice in hospitals."

One of the founders of the family practice residency at the University of Maryland and the founder of the Prince George's County Hospital's department of family practice and family residency program, Dr. Lilly believes it is essential to have an adequate primary care role model in the medical school setting. He points out that with a growing managed care marketplace, "we need to train our primary care physicians fully." He says that, in addition to strong foundations in internal medicine and pediatrics, the essentials include a basic, solid foundation in female reproduction/physiology, psychiatry, outpatient medicine, minor office orthopedics, minor surgery, and dermatology. He believes that "well-trained primary care physicians can handle most of what comes into the office and what they cannot handle can be referred to many fine specialists." He says not a day goes by that he doesn't call a specialist for a



J. Richard Lilly, M.D.

problem; that is why he thinks it is important to have a well-integrated system with primary care physicians and specialists working together to care for patients.

Managed health care

Pointing out that 66% of all health care in California is managed health care, Dr. Lilly admits, "The marketplace will determine much of what will happen and it appears that managed care will gain a larger percentage of the market." He is disturbed, however, by the news of huge profits being amassed by HMOs: "Some of that money needs to be returned to the health care system to reduce costs and provide some coverage for the uninsured."

Dr. Lilly acknowledges that there have been many controversies associated with the management of some HMOs. "Nevertheless," he states, "it is our ethical obligation as physicians to provide quality care to patients regardless of their health insurance status and to maintain legislative vigilance to ensure that all HMOs provide adequate coverage for good health care."

In light of the penetration of managed care, Dr. Lilly encourages all physicians to be involved at all levels, including board appointments. He thinks it is particularly important to be actively involved in committees, because physicians have considerable influence at this level. Dr. Lilly says that in his experience, most HMOs are receptive to and desirous of physician participation. He stresses that there must be a partnership for physicians to maintain the quality of care for their patients: "We can't allow quality of care to erode because of the financial concerns or convenience of a managed care organization." Without a partnership between physicians and management, says Dr. Lilly, this form of health care could fail.

Patient/physician relationship

Dramatic changes have occurred in medicine. Dr. Lilly recalls the time when physicians made house calls, communities were tightly knit, and physicians were well-known members of the community. He says house calls have become a thing of the past primarily because emergency rooms, with their significant technological advances, have taken their place. Although life-threatening illnesses cannot wait for a physician to make a house call, Dr. Lilly believes house call services should be maintained for patients—primarily the elderly—who are housebound.

Dr. Lilly thinks the status of physicians has eroded in the minds of the public. Part of the reason, he feels, is the high number of legal suits brought against physicians, which naturally affects the health care system: "We now have to practice defensive medicine. That is extremely onerous to the practice of medicine in this country. Tort reform is mandatory. In addition, antitrust legislation must be enacted to reduce the cost of health care."

Dr. Lilly points out another factor that has affected the patient/physician relationship: the likelihood that patients will change physicians if their health plan changes. He cites a recent *New York Times* article that observed that although many people expected patients to rebel against switching physicians, patients do not seem to mind. "That," he says, "is sad testimony to the changes that are occurring in health care."

The uninsured

Dr. Lilly shares the sentiments of many physicians when he says, "We must address the medical needs of the uninsured in this country." But he doubts that anything will happen under the current administration because President Clinton excluded organized medicine from the process. Dr. Lilly stresses that the American Medical Association has been very proactive in the area of health system reform, but the Clinton administration unfortunately did not choose to use the available AMA information resources.

Med Chi and Maryland medicine

Dr. Lilly believes that Med Chi's role in preserving the quality of health care has been and continues to be significant. He is confident Med Chi will have a very healthy relationship with Governor Parris Glendening. "He has always been a friend to medicine. The doctors have always felt he is someone with whom they can have a substantive dialogue."

Dr. Lilly is also pleased about the reorganization at Med Chi. He points out that Med Chi's structure now parallels that of the AMA, "which is a far better way to run an organization."



Dr. Lilly and his sons, John and Donald.

Personal background

Dr. Lilly, who grew up in a working class community in Baltimore, Maryland, planned to be a physician early in life. His uncle, Melvin Davis, M.D., had a large general practice in Dundalk, and Dr. Lilly often made house calls with him while still a high school student at Baltimore City College. "My uncle was the role model who inspired me to pursue a career in medicine."

Dr. Lilly received his bachelor's degree in chemistry from Gettysburg College in Pennsylvania, where he also received varsity letters in track and swimming. After earning his medical degree at Temple University School of Medicine in Philadelphia, he completed an internship at Church Hospital in Baltimore.

Commissioned a lieutenant in the U.S. Navy, Dr. Lilly trained as a submarine and diving medical officer. He was later stationed at a small navy base where, in his free time, he helped a family physician in an underserved community. He found significant satisfaction from the experience: "I enjoyed practicing in the primary care setting so much that I abandoned my goal of becoming an obstetrician/gynecologist and decided to be a primary care physician."

When he first started his private practice in the mid-1960s, Dr. Lilly practiced a combination of family medicine and obstetrics. During that time, he delivered the son of our current governor, the Honorable Parris N. Glendening (Dr. Lilly remains the family physician for the first family). Also during his early years of practice, he and a small group of physicians provided house call services, serving the Dundalk, South Baltimore, East Baltimore, and Towson areas. Dr. Lilly explains, "Other doctors would sign out their patients to us. In those days, an office visit was three dollars and a house call was five dollars—and in the 1960s, five dollars was a lot of money." Dr. Lilly says the experience provided invaluable training for the management of acute care, as well as experience in family dynamics. It also made him aware of a void in the medical care system and the need to integrate family practice into that system.



Dr. Lilly and his wife, Elizabeth, enjoy a quiet moment on Block Island.



Dr. Lilly inspects his lobster catch.

Dr. Lilly eventually stopped practicing obstetrics because the cost of malpractice insurance exceeded his income from obstetrical care. He currently is the senior partner in a group of ten physicians who maintain offices in Silver Spring, College Park, Riverdale, and Hyattsville.

As he urges other physicians to do, Dr. Lilly became involved with boards and committees shortly after entering practice. He served on the executive committee of both Prince George's General Hospital and AMI Doctor's Community Hospital in Lanham, Maryland, of which he was a founding partner. He continues to serve on the board of trustees of Doctor's Community Hospital. He has been involved in organized medicine as a past president of the Maryland Academy of Family Physicians and the Prince George's County Medical Society. He has served as a member and chairperson of numerous Med Chi committees and held the office of vice-president in 1987.

A boating and water sports enthusiast, Dr. Lilly is also an avid swimmer. He swims three to four times per week and waterskis and dives whenever possible. His family shares his love of the water; during the late 1970s, they competed in bill fishing tournaments out of Ocean City, Maryland, and he still enjoys piloting his boat, the *Alter Ego*, with his family. During the summers, the Lillys make time in their busy schedules to cruise the Atlantic coast to New England, where they particularly enjoy Nantucket, Martha's Vinyard, and Block Island. Dr. Lilly also has cruised the Bahamas extensively and is especially proud of his numerous Gulf Stream crossings.

Dr. Lilly's wife, Elizabeth Ann Lilly, M.D., is a board-certified psychiatrist specializing in child psychiatry. His oldest son, John, is a circuit court prosecutor in Prince George's County and an officer in the Naval Reserve. His youngest son, Donald, has his own interior design business in Florida. The Lillys have two grandchildren. ■



Dr. Lilly relaxes with his grandsons, Johann and Cameron.

Long-term clinical and prostate-specific antigen follow-up in 500 patients treated with radiation therapy for localized prostate cancer

Cengiz Aygun, M.D., Julia Blum, M.D., and Linda Stark, P.A.-C.

From Radiation Oncology Affiliates of Maryland (Baltimore), where Dr. Aygun is medical director, Dr. Blum is a radiation oncologist, and Ms. Stark is physician assistant.

ABSTRACT: *During a 14-year period, 500 consecutive patients having localized prostate cancer were treated with external beam radiotherapy with curative intent. Patients were staged according to the Whitmore-Jewett and TNM systems. Median follow-up for all patients was 69 months. Local recurrence included failures detected by rectal examination and/or prostate biopsy. Progressively elevated prostate-specific antigen (PSA) values at follow-up with no evidence of systemic disease also was considered a local treatment failure. Overall 5- and 10-year survival rates were 65% and 37%, respectively. Cause-specific 5- and 10-year survival rates were 79% and 55%, respectively. Five- and 10-year local control rates for all patients were 72% and 52%, respectively. No patient with a T1a tumor failed locally. When follow-up PSA data were included in control criteria, 10-year local control rates for patients with T1b, T2a, and T2b-T4 tumors were 66%, 55% and 44%, respectively. If only an abnormal rectal examination and/or a positive post-treatment biopsy was considered as evidence of local failure, control rates were significantly better. Approximately one third of the study patients had died of cancer or intercurrent disease before the PSA test was used routinely. Of the 244 patients (49%) for whom follow-up PSA values were available, 116 had a normal post-treatment PSA with no evidence of disease; 94 were alive and 22 died with no evidence of prostate cancer. Of 124 patients who had an elevated PSA after therapy, 14 (11%) had biopsy-proven local failure; 43 (35%) had evidence of systemic disease associated with the increased PSA;*

Reprints: *Cengiz Aygun, M.D., Franklin Square Radiation Oncology Center, 9105 Franklin Square Dr., Baltimore, MD 21237.*

and 67 (54%) had no evidence of local or systemic disease, but were assumed to have local failure (of these 67 patients, 27 are still being observed with no treatment—13 for more than 2 years). Fourteen patients with an elevated PSA alone died without any evidence of progression or any treatment. The remainder received hormonal manipulation.

Table 1. Diagnostic and histologic data

Method of diagnosis	Number	(%)
▾ needle biopsy	246	(49)
▾ needle biopsy and TURP*	77	(15)
▾ TURP	176	(35)
▾ unspecified	1	
Histology		
▾ well differentiated	132	(26)
▾ moderately differentiated	271	(54)
▾ poorly differentiated	82	(16)
▾ unspecified	15	(3)

TURP = transurethral resection of the prostate

Prostate cancer is now the most common cancer in the United States; 200,000 new cases were expected in 1994.[1] A high index of suspicion, increased public awareness, longer life expectancy, and the emergence of prostate-specific antigen (PSA) have contributed to the increased diagnosis of this disease. Parallel to the increased overall incidence, there is now a higher prevalence of early stage prostate cancers[2] that have generated considerable debate regarding treatment; prostatectomy, radiation therapy, or observation with no treatment may be appropriate management. For more advanced stages, surgery, radiotherapy, or hormonal manipulation are the usual treatment options.

Because the natural course of prostate cancer can be indolent, long-term follow-up is essential to draw conclusions regarding treatment. In addition, the rather advanced age of patients at diagnosis and the frequent coexistence of other medical problems make it difficult to evaluate treatment efficacy. Local treatment assessment may be further confounded by the use of hormones in patients who develop systemic disease.

External beam radiotherapy has been used in the management of localized prostate cancer since the 1960s. Although the literature contains many references, there are few published long-term studies involving a large number of patients from a single institution.[3-8]

Methods and materials

From June 1975 to September 1989, 1030 men with a diagnosis of prostate cancer were evaluated and treated by

Table 2. Prostate cancer staging

	Modified Whitmore-Jewett*	TNM
	A_1 ..... tumor not palpable; focal, well differentiated	T1a ..... incidental tumor in < 5% of resected tissue
	A_2 ..... tumor not palpable; diffuse, poorly differentiated	T1b ..... incidental tumor in > 5% of resected tissue T1c ..... nonpalpable tumor (PSA detected)
	B_1 ..... tumor palpable, limited to one lobe	T2a ..... tumor involves less than half a lobe T2b ..... tumor involves more than half a lobe
	B_2 ..... tumor palpable, involves both lobes	T2c ..... tumor involves both lobes
	C_1 ..... tumor extends beyond prostatic capsule	T3a ..... unilateral extracapsular extension T3b ..... bilateral extracapsular extension
	C_2 ..... bulky tumor with more local extension	T3c ..... extracapsular and seminal vesicle involvement T4 ..... tumor fixed or invading bladder or rectum

** *Diagrams reprinted with permission from Catalone WJ: Prostate Cancer, New York, Grune & Stratton, 1984.*

Table 3. Stage at diagnosis

Whitmore-Jewett	Number (%)	TNM	Number (%)
A_1	18 (4)	T1a	18 (4)
A_2	61 (12)	T1b	61 (12)
B_1	144 (29)	T2a	144 (29)
		T2b	44 (9)
B_2	175 (35)	T2c	131 (26)
C	102 (20)	T3a-c	98 (20)
		T4a	4 (<1)

Radiation Oncology Affiliates of Maryland (ROAM). Of these, 500 patients had localized prostate cancer treated with curative intent using external beam radiation therapy. These patients constitute the study population. Exclusion criteria were: 1) evidence of regional or distant metastases at presentation; 2) prior treatment with surgery; 3) prior or concomitant hormonal therapy; 4) initial expectant management lasting months to years, with therapy only at the time of local progression; 5) locally advanced disease treated palliatively with a short course of radiation. The 500 study patients (442 white, 58 black) were included in the data analysis regardless of their initial performance status. Patients' median age was 69 years (range, 46 to 92). Clinical and histologic information is shown in **Table 1**.

All patients were staged according to the Whitmore-Jewett and TNM systems (**Table 2**). Disease stage at diagnosis is shown in **Table 3**. Pretreatment studies included bone scans in 470 patients (94%), acid phosphatase in 440 (82%), computed tomography of the pelvis in 196 (39%), and PSA determinations in 33 (7%). Among the latter, PSA levels were elevated in 26 (79%). The median pretreatment PSA level was 16 (normal, 0 to 4). Ultrasound or magnetic resonance imaging (MRI) was rarely used for staging.

All patients were treated using megavoltage external beam radiotherapy, Cobalt 60 or 6-15 MV photons. In the earlier years of the study, patients received 3960 cGy (180 cGy/day) to the true pelvis followed by a 2000 to 2500 cGy boost to a smaller field encompassing only the prostate gland. The boost field was treated using relatively "large" 250 cGy/day fractions. In the later years, 180 to 200 cGy daily fractions were used throughout the treatment course (pelvis and boost fields) to total doses of 6000 to 7020 cGy. If the radiation oncologist felt that the disease was limited and/or the medical condition of the patient was poor, only the "boost" field encompassing the prostate gland and a small amount of periprostatic tissues was used for the entire treatment course.

Patients were seen at regular post-treatment intervals and routinely received a physical examination, including a rectal examination. In recent years, follow-up also included a PSA determination. Post-treatment evaluations were obtained from ROAM, referring urologists, hospital records, and patients and/or families (in some cases).

Overall survival, cancer-specific survival, disease-free survival, and local control were calculated by the Kaplan-Meier actuarial method.[9] Overall survival took into account all causes of death. For cancer-specific survival, only death caused by prostate cancer was counted as an event; death caused by intercurrent disease was treated as a censored observation. For disease-free survival, the persistence or reappearance of prostate cancer was counted as an event regardless of the location (local or distant). Local recurrence included failures detected by rectal examination and/or prostate biopsy. Progressive elevation of the post-treatment PSA with no evidence of systemic disease was also considered a local failure in the analysis.

Table 4. Overall and cancer-specific survival rates following radiotherapy

Stage	Number at risk	5-Year overall survival	5-Year cancer specific survival	Number at risk	10-Year overall survival	10-Year Cancer specific survival
T1a	15	89%	100%	4	76%	100%
T1b	44	79%	93%	4	57%	83%
T2a	105	78%	92%	27	44%	69%
T2b-T4	142	53%	67%	29	28%	40%
All stages	306	65%	79%	64	37%	55%

Results

The overall (death from any cause) 5- and 10-year survival rates for all 500 patients were 65% and 37%, respectively. Cancer-specific 5- and 10-year survival rates were 79% and 55%, respectively. Overall and cancer-specific survival rates were analyzed by stage (**Table 4**). The 5- and 10-year disease-free sur-

Table 5. Local control rates following radiotherapy

Stage	Number at risk	5-Year local control (%)		Number at risk	10-Year local control (%)	
T1a	15	100*	100**	4	100*	100**
T1b	35	82*	94**	3	66*	76**
T2a	84	76*	84**	20	55*	71**
T2b-T4	105	66*	75**	19	44*	59**
Overall	239	72*	81**	46	52*	67**

* Local failure based on abnormal rectal examination, positive prostate biopsy, or elevated PSA
** Local failure based only on abnormal rectal examination or positive prostate biopsy

vival rates for all patients were 52% and 33%, respectively. The median survival after the development of metastatic disease was 27 months.

In 109 patients, there was evidence of local failure by an enlarging mass on rectal examination or a positive post-treatment biopsy (performed because of clinical indications). In 67 patients, determination of local failure was based solely on an increasing PSA level after treatment. The actuarial median time to local failure for all patients was more than 10 years (129 months). After 10 years of follow-up, 40 patients were still at risk for local failure; of these, 10 subsequently developed a local recurrence (7 biopsy-proven and 3 based on elevated PSA). Five- and 10-year local control rates by stage are shown in **Table 5**. If evidence of local failure is only considered to be an abnormal rectal examination and/or a positive post-treatment biopsy, then control rates were significantly better (**Table 5**).

Table 6. Long-term radiation side effects in 500 patients

Self-limited	**Number (%)**
▾ Diarrhea requiring Lomotil	21 (4%)
▾ Rectal bleeding (intermittent)	35 (7%)
▾ Hematuria (intermittent)	4 (1%)
Minor surgical intervention required	**Number (%)**
▾ Rectal bleeding, laser surgery	3 (< 1%)
▾ Hematuria, laser surgery	10 (2%)
▾ Urethral stricture requiring dilation*	14 (3%)
Major surgical intervention required	**Number (%)**
▾ Rectal stricture	2 (< 1%)
▾ Small bowel perforation/obstruction	3 (< 1%)

* 13 patients had pretreatment TURP

Approximately one third of the patients in the study population died of cancer or intercurrent disease before the PSA test was used routinely. Follow-up PSA data (median time, 77 months) were available for 244 patients after radiation therapy. Of these, 116 had a normal post-treatment PSA with no evidence of disease; 94 patients were alive; and 22 had died of other causes while free of cancer. Four patients had a normal PSA with evidence of distant metastases.

After radiation therapy, 124 patients had an elevated PSA. Biopsy-proven local failure accounted for the elevation in 14 (11%). There was evidence of systemic disease associated with the increased PSA in 43 patients (35%). In 67 patients (54%), there was no evidence of local or systemic disease; 53 patients are still alive and 14 have died. The 53 living patients were followed a median of 73 months since treatment; of these, 27 are still being observed without any treatment (13 for more than 2 years). The remainder received hormonal manipulation.

Gastrointestinal and urinary complaints were the most common acute side effects reported by patients during therapy. Symptoms consisted mainly of diarrhea, rectal burning and itching, and urinary frequency; they were transient and generally subsided shortly after the completion of therapy. Significant long-term morbidity was low. Only 1% of patients required hospitalization or major surgery for a treatment-related side effect (see **Table 6**).

Discussion

There are only a few published studies of the long-term outcome of a large number of prostate cancer patients treated with radiotherapy at a single institution. Since the introduction of PSA, numerous reports with short-term follow-up have been published. The current study examined 500 patients with a median follow-up of 69 months (more than 10 years in 64 patients), including a substantial number of patients for whom long-term PSA data are available.

The average age at presentation was 69 years; thus, it is not surprising that the overall 5- and 10-year survival rates were 65% and 37%, respectively. There was a high incidence of intercurrent deaths, as evidenced by a 5-year cancer-specific survival rate of 79% and a 10-year rate of 55%.

Overall local control rates for our patients were 72% at 5 years and 52% at 10 years. As expected, control rates are better for earlier stages of disease. It is important to note that unlike other malignancies, prostate cancer may be very indolent, with a significant number of local failures becom-

Table 7. 10-Year survival of patients treated with external beam radiation

Institution	Stage	Number of patients	Survival
▾ M.D. Anderson Hospital[3]	B	82	70%
	C	551	57%
▾ Yale University[4]	A_2-B	168	38%
	C	121	21%
▾ Washington University[3]	A_2	41	66%
	B	185	55%
	C	328	35%
▾ Stanford University[3]	T1 (A)	282	60%
	T2 (B)	183	55%
	T3 (C)	348	35%
	T4 (C)	32	12%
▾ Radiation Oncology Affiliates	T1a	18	76%
	T1b	61	57%
	T2a	144	44%
	T2b-T4	277	28%

Table 8. 10-Year local control with external beam radiation

Institution	Stage	Number of patients	Survival	
▾ M.D. Anderson Hospital[5]	A_2	104	79%	
	B	168	68%	
	C	602	76%	
▾ Princess Margaret Hospital[6]	T1	70	92%	
	T2	341	75%	
	T3	362	58%	
	T4	172	37%	
	UICC 1978			
▾ Patterns of Care survey[7]	A	60	97%	
	B	312	74%	
	C	296	69%	
▾ Washington University[8]	A_2	48	80%	
	B	252	76%	
	C	412	60%	
▾ Radiation Oncology Affiliates	T1a	18	100%	100%*
	T1b	61	76%	66%*
	T2a	144	71%	55%*
	T2b-T4	277	59%	44%*

* Includes local failures based on elevated PSA only

ing apparent only after 5 years of follow up. In our group, 239 patients had no evidence of local failure 5 years after completing radiotherapy; of these, 51 subsequently developed a local failure. **Tables** 7 and **8** compare our survival and local control data with other published studies involving large numbers of patients.

Local control after radiation for prostate cancer can be a difficult endpoint to evaluate. Even among untreated patients, MRI and ultrasound do not have the high predictive values initially expected.[10,11] In the past, local control was based primarily on the post-treatment rectal examination with follow-up biopsies when findings were suspicious. Thus, local tumor control rates as determined by clinical examination alone may be overestimated. Even glands that feel normal may harbor residual cancer detectable on biopsy.[12] The post-radiotherapy positive prostate biopsy has been the subject of debate for many years. The initial notion of its having no significant impact on ultimate outcome has now changed.[13] Patients with persistent tumor on biopsy are generally believed to have a worse prognosis.[12] Prestidge and colleagues[14] reported a Stanford University study involving 116 patients with positive post-radiation biopsies. Although survival was poorer when the patients also had abnormal digital rectal examinations, the median actuarial survival for the entire group was 5.2 years after rebiopsy. The authors concluded that routine rebiopsy without clinical indications is not a useful practice. Hormonal intervention for systemic or chemical failure also may affect local tumor growth, thus creating another difficulty in assessing the efficacy of radiotherapy as a local treatment modality.

Available long-term follow-up data regarding local control were obtained prior to the PSA era. With the availability of PSA, assessment of local control may become more accurate. As expected, with the addition of PSA in the post-treatment evaluation, local failure rates are higher. In the

current analysis, PSA elevation in the absence of proven systemic disease was attributed to local failure. Only with additional follow-up will it be possible to determine if the rising PSA is secondary to local failure or due to subclinical systemic disease. Almost half our patients with local failure based solely on an elevated PSA are still being followed; quite a few have been followed more than two years with no treatment and are doing well.

Long-term follow-up (more than five years) is critical in the evaluation of any treatment for prostate cancer. The incorporation of PSA into the follow-up may be the most reliable means of assessing the success of local therapy. The timing of additional therapy after a treatment failure based on PSA alone, however, remains to be determined. In patients with locally advanced disease, failure rates are higher than we would like. Other management methods being evaluated for such patients include conformal 3-dimensional radiation therapy, which may deliver higher doses of radiation without increased side effects, and adjuvant hormonal therapy in addition to radiation.[15,16] For patients with early stage disease, treatment with radiotherapy offers a good chance at local control with minimal morbidity. Furthermore, for early stage disease, the survival results associated with radiotherapy are similar to the life expectancy of an age-adjusted normal population.[8] The challenging question is whether observation alone should be considered until the patient shows evidence of disease progression.[17,18] Serial PSA values are a good predictor of tumor biology and may assist clinicians in this decision.

Prostate cancer is a disease in which host and tumor factors have important prognostic significance. Very few prospective studies are available from which to draw conclusions and their data do not warrant endorsement of any specific treatment at this time.[19,20] Only prospective controlled studies with large numbers of patients and long-term follow-up will clear the existing confusion and ongoing controversy. Until these questions are answered, it is reasonable to individualize therapy for each patient, taking into consideration his stage of disease, age, medical condition, and personal wishes.

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Case report: management of left ventricular aneurysm and an intraventricular mass using perioperative transesophageal echocardiography

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Mobile tumors are commonly reported to occur in the right side of the heart. Left ventricular mobile tumors are very rare.[1] A case of left ventricular aneurysm with thrombus formation and an intraventricular mass is reported. The patient's relatively young age, lack of coronary artery disease, and negative history of drug abuse led to a diagnostic and therapeutic dilemma. Preoperative and intraoperative transesophageal echocardiography (TEE) was extremely helpful in the diagnosis and management of this case.

Case report

A 36-year-old, obese black woman with diabetes and hypertension was referred to our institution after suffering a right cerebral hemisphere infarct. The patient had had an anterolateral myocardial infarction nine years previously. She denied alcohol and drug abuse or any history of trauma. Her medications included atenolol 50 mg and chlorpropamide 5 mg per day. She presented with left-sided weakness of two days' duration, but no distress. She was alert and oriented with a right gaze preference, left facial droop, and tongue deviation to the right. Motor strength was 1/5 on the left and normal on the right. Computed tomography of the head showed a large right frontal infarct. Cardiac examination showed a normal S_1 and S_2, distant heart tones, and a grade II/VI systolic ejection murmur at the apex. Echocardiography revealed a left ventricular aneurysm with wall calcification. Also present was a 2 cm x 5 cm mass in the left ventricle, extending into the left ventricular outflow tract.

Electrocardiogram showed Q waves in leads I and aVL, poor R wave progression anteriorly, and inverted T waves laterally, all of which are consistent with an anterolateral myocardial infarction. Transesophageal echocardiography (TEE) confirmed the presence of a 2 cm x 5 cm mobile mass in the left ventricle that protruded into the left ventricular outflow tract and at times through the aortic valve. The left ventricular apex was

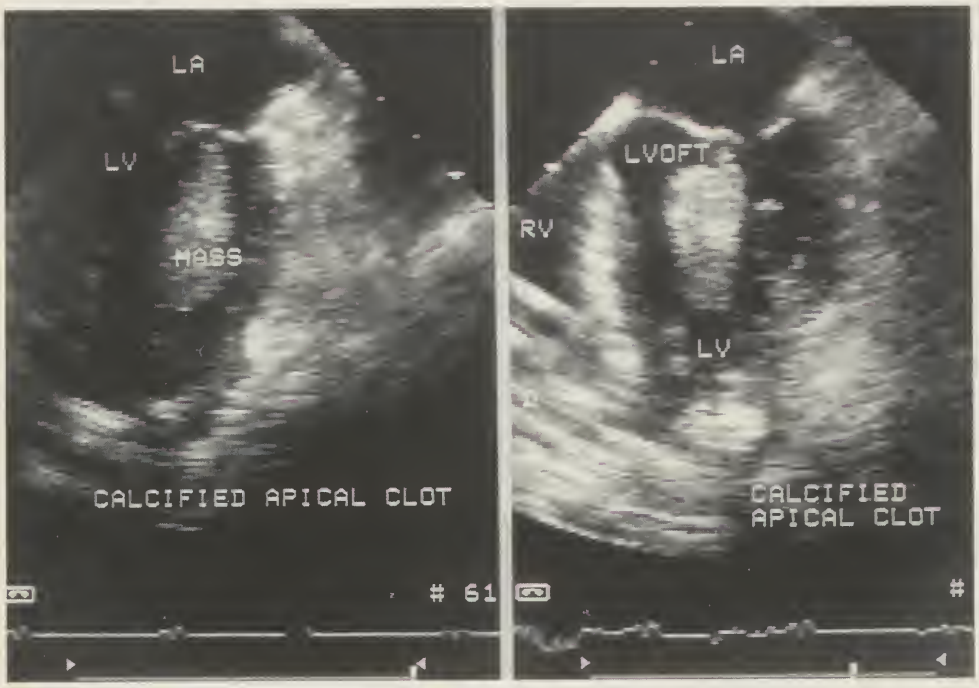


Figure 1. Vertical and horizontal views showing the mobile mass in the left ventricle and calcified apical clot.

akinetic to dyskinetic with calcification of the wall (see **Figure 1**). Cardiac catheterization revealed normal coronary arteries despite the presence of the ventricular aneurysm and the previous history of myocardial infarction. The patient was systemically heparinized and follow-up echocardiograms at one and two weeks showed no change in the size of the mass. At that time, the patient was referred for surgical repair of the aneurysm and removal of the mass to determine if it was truly a thrombus or possibly an intracardiac tumor.

Hemodynamic monitoring was established and general anesthesia was induced with midazolam, fentanyl, and vecuronium. After the patient was intubated endotracheally, a Hewlett Packard Biplane TEE probe was inserted. The TEE examination confirmed the preoperative findings. A median sternotomy incision was made and appropriate cannulation was performed for cardiopulmonary bypass. Once bypass was initiated, the left ventricular apex was sharply dissected from the pericardium where it was markedly adherent. Heavy calcification was palpable in the left ventricular wall. The aorta was cross-clamped, cardioplegia was given into the aortic root, and the heartbeat was arrested; moderate hypothermia was maintained during the procedure. The calcified aneurysm wall was incised with heavy scissors. No thrombus was present in the aneurysm wall on gross examination. The intraventricular mass was found to be adherent to chordae tendinea of the anterior papillary muscle, which allowed the mass to move in and out of the left ventricular outflow tract with myocardial contraction (**Figure 2**). The chordal attachments were sharply divided without injury to the chordae tendinea and the mass was removed. The transition zone between healthy myocardium and aneurysm wall was identified and an elliptical patch of polytetrafluoroethylene was sewn to the margin using running O-polypropyline suture. The calcified material from the aneurysm wall was removed



Figure 2. Intraventricular mass with chordal attachment before excision.

and the wall closed over the patch with the same suture material.

Cardiopulmonary bypass was weaned without difficulty. Postpump TEE confirmed removal of the ventricular mass and repair of the ventricular aneurysm. TEE was also helpful in assessing myocardial and valvular function during the postpump period. Pathologic examination confirmed that the mass was an encapsulated, organized thrombus measuring 2 cm x 5 cm. A portion of the aneurysm wall was described as calcified connective tissue. The patient tolerated the procedure well, had a routine postoperative recovery, and was transferred to a rehabilitation facility for physical and occupational therapy.

Discussion

Thrombus formation, a common occurrence in calcified left ventricular aneurysms, is due to blood stagnation within the akinetic wall of the aneurysm at the end of each cardiac cycle.[2] The immobilization of the apex by adhesions to the pericardium further contributes to the stagnation.

We postulate that the thrombus, once adherent to the aneurysm wall, broke away, thus causing the embolic event leading to the patient's stroke. Adherence of the intraventricular thrombus to the chordae tendinea probably prevented further catastrophe in this patient.

The etiology of the myocardial infarction leading to aneurysm formation remains unknown. No coronary artery disease was identified on cardiac catheterization and the patient denied any history of drug abuse or trauma. Left ventricular aneurysms have been reported in young blacks with African heritage, but these aneurysms usually are not associated with previous myocardial infarction.[3] Small vessel coronary artery disease may lead to myofibrillar hypertrophy and patchy fibrosis.[4] Angiography shows patent coronary arteries, but sluggish blood flow. Small vessel disease and pathologic coronary vasospasm cannot be ruled out entirely. Acute myocardial infarction leading to left ventricular thrombi and systemic embolization is an important cause of morbidity and mortality.[5] The organized, laminated thrombi associated with left ventricular aneurysms differ pathologically from thrombi that form in association with acute myocardial infarction. Acute thrombi are more likely to be mobile and friable and to project into the lumen, and thus are more likely to embolize.[6,7]

Simpson and coworkers[8] found that, although the prevalence of mural thrombi is high in left ventricular aneurysms, embolization is rare and routine anticoagulation has negligible effects on frequency of embolization. These conclusions were reiterated by Reeder and colleagues[9] and Cobin and Roberts,[10] who added that patients with left ventricular failure after transmural anterior infarction might benefit from anticoagulation in the early post-infarction period.

TEE is invaluable for preoperative identification of cardiac masses and thrombi, as well as evaluation of cardiac and valvular function. TEE also is very helpful for intraoperative assessment of myocardial function, especially during the weaning phase of cardiopulmonary bypass.[11,12] Finally, TEE is extremely useful for detection of intracardiac air.

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FOOD FOR THOUGHT

"*The secular trend toward increased body fat in each successive generation may be more easily explained by the availability of gasoline than by the availability of fast food*" (Bennett WI. Beyond overeating. *N Engl J Med* 1995;332:673-674).

Civil War antisepsis and infection

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During the U.S. Civil War, both the Union and Confederate medical corps attracted a diversity of medical talent. Some of the best known surgeons of the day took their respective sides, joined by a plethora of recently graduated and inexperienced physicians with as much yearning to gain surgical experience as to serve their patriotic causes. Whereas a surgeon in civilian practice would rarely have to treat a gunshot wound, a military surgeon may have had to treat hundreds over the course of a few days.

The U.S. Sanitary Commission was established in June 1861, in accordance with the recommendation of the Surgeon General of the Army. The Sanitary Commission was instrumental in improving medical conditions for Union soldiers. The Commission worked effectively in the field hospitals and general hospitals, supplying information and literature, as well as a caring heart, to thousands of injured soldiers. Although medical authors of the Civil War period had available to them the morbidity and mortality statistics from the Crimean War, the experience gained from that conflict added little to the armamentarium of the Civil War surgeon when it came to combating infection. This article discusses the issues of antisepsis and infection. The former was a foreign concept to the Civil War surgeon; the latter was viewed as an expected step in the healing process of wounds. The indications, techniques, and results of military surgery during the Civil War have been described elsewhere.

Antisepsis

Because Lister's landmark work on antisepsis was published in 1867, it has been assumed that Civil War surgeons had no antiseptics. However, surgeons of that period had access to a number of agents with antiseptic properties, such as carbolic acid, chlorine, charcoal, and sodium hypochlorite. Other agents with antiseptic value used by physicians during the period were iodine; bromine; acids such as sulfuric, hydrochloric,

nitrous, and nitric; and alcohol, usually in the form of whisky. The problem was not in recognizing their antiseptic properties, but in using them at the right time. The occurrence of widespread infections stemmed from the ignorance of the nature, cause, method of communication, and treatment of infections. Infections were allowed to advance to such a stage that when an antiseptic was applied, it had little chance of effecting a cure.

One of the medical advances of the Civil War was the realization that hospital cleanliness was necessary for the health and recovery of patients with healing wounds. The cleansing ability of heat was known; many effective antiseptics were used to clean hospital floors, urinals, bedpans, and latrines; and agents such as bromine were effectively sprayed into the air in hospitals during outbreaks of erysipelas. It is bewildering, therefore, that no one thought it necessary to use clean surgical instruments.

Surgeons operated with bare hands in blood- and pus-stained aprons or overcoats and never washed their hands between surgical cases. They were often seen clenching an amputation knife or other instrument between their teeth during the often feverish pace of up to six operations per hour. If time allowed, the ebony or ivory-handled surgical instruments were washed at the end of a day of operating—not in the interest of antisepsis or the prevention of infection, but simply to prevent their rusting. At times, however, water was so scarce that not only would instruments remain unwashed for days, but surgeons were unable to wash their hands at the end of the day as well. It is also remarkable that any wound escaped infection after daily washings from the same pus-laden basin water and sponge used to cleanse every wound on the ward.

When morphine or opium were in short supply, instead of liberally sprinkling the substances on wounds, a surgeon would sometimes sprinkle a small amount on a saliva-moistened finger and then massage it onto a wound. The endermic method of injecting morphine with a syringe was rarely used in the early stages of the war, although it later gained widespread use after surgeons learned of its effectiveness and economy in conserving morphine.

We now know that postoperative dressings promote healing and prevent contamination of wounds, but the dressings used during the Civil War often failed to meet either objective. The usually clean, but nonsterile lint, absorbent cotton, gauze, or linen used for dressings was nearly always applied wet and kept wet by either allowing a constant drip of water on it or by allowing a length of dressing to hang off the wound immersed in a vessel of water, which kept the wound wet through the wick effect.

Osnaburg, manufactured by a number of cotton textile factories, was used to make bandages. The Sanitary Commission in the North and women in the South also furnished worn clothes, old linen, sheets, and bedspreads, which could either be cut into strips and used as bandages or scraped with a knife to make lint for bandages. Raw cotton baked in an oven until it just began to char was often substituted when lint was unavailable and, as a result of its method of preparation, was rendered relatively aseptic. (Another accidental aseptic procedure employed during the Civil War was the use of boiled horse hair for ligatures and sutures when the preferred silk thread was not available. Boiling rendered the horse hair soft and flexible and, thus, able to be used as sutures and ligatures.) When dressings were scarce, however, an old rag or strip of sweaty shirt was used or, even worse, old dressings were washed and reused on different patients. This economical practice was even suggested by the Sanitary Commission.

The "laudable pus" that occurred almost universally in wounds three to four days post-operatively was viewed as a natural step in the healing process; the unusual occurrence of a wound healing without generous drainage and odor was thought to be a curious medical aberration. By the end of the war, the expected postoperative signs and symptoms of pain, high fever, and abundant discharge of pus from a wound were generally recognized to herald some type of infection, but no physician could recommend effective treatment, discover a causative organism, or conclusively determine a means of transmission.

Infection and disease

Of the more than 600,000 casualties of the Civil War, about two-thirds resulted from diseases. The most common disease killers were typhoid, acute and chronic diarrhea, dysentery, and typho-malarial fever. Of the approximately 200,000 fatalities remaining, nearly as many occurred as an aftermath of wounds inflicted in battle as occurred on the battlefield. The majority of wounded soldiers who survived the battlefield died from infectious processes such as pyemia, hospital gangrene, erysipelas, and tetanus. Even though an abundant discharge of pus from a wound was both welcome and expected as a normal step in the healing process, the above four conditions were greatly feared.

Tetanus. Tetanus, the least common of these conditions, was felt to be caused by exposure to cold drafts, cold or damp weather, excessive pressure on nerves, nerve injury, the absence of early wound cleansing, or the suppression of certain natural secretions. In his *Manual of Military Surgery*, Samuel D. Gross, M.D., taught that tetanus was most

likely to show itself in hot, damp weather and in persons of a nervous, irritable temperament or when the climate of the wounded was changed from hot to cold or from dry to wet. The 550 cases of tetanus reported during the Civil War carried an 89% mortality rate. Dr. Gross realized that tetanus was preventable, but published the ineffective dictum, "To prevent this disease should be our business, and to do this no wounded person should ever be exposed to the cold night air, or to currents of air at any time" (p. 97).

Civil War surgeons did not benefit from the knowledge that tetanus is caused by the widespread anaerobic bacillus *Clostridium tetani*, which is frequently found both in the soil and intestines of horses. The relatively low incidence of tetanus during the Civil War can be attributed to two conditions. First, the majority of Civil War battles were fought on virgin soil that had not been plowed or fertilized with horse manure. (It is noteworthy that a documented flare-up of tetanus occurred at a field hospital at Antietam, which was an old stable in which manure needed to be cleared from the floor before the building could be used as a hospital.) Second, the anaerobic conditions necessary for the tetanus bacillus' survival were often thwarted by Civil War surgeons. The generally accepted treatment of a gunshot wound was prompt amputation of the limb proximal to the wound. Thus, the great majority of deep wounds contaminated with the tetanus bacillus would have been discarded with the limb at the time of amputation.

Although there was no effective treatment for tetanus during the Civil War, numerous remedies were tried, such as brandy, alcohol, quinine, morphine, opium, camphor, antimony, nasogastric tube feedings, enemas, belladonna, and woorara poison. Woorara was used empirically because of its ability to counteract the effects of strychnine. The striking similarity between the spasms produced by strychnine and those of tetanus prompted Dr. John Julian to suggest its use in the latter disease.

Erysipelas. A very contagious streptococcal infection, erysipelas plagued Civil War surgeons and their soldier patients. Its characteristic rash was accompanied by "violent inflammatory symptoms, intense swelling, tension, redness, pain, heat and effusion" (Chisolm, p.193). Medical authors and surgeons of the day also recognized erysipelas as being "clearly contagious, as well as infectious" (Chisolm, p. 195). Erysipelas was associated with conditions such as overcrowding, bad ventilation and an unclean environment. Prevention was effected much easier than a cure, however, and "therefore, our first care should be by the strict observance of those hygienic regulations for ventilation and cleanliness and against overcrowding—to keep the wards of a hospital with so pure an atmosphere as to give no encouragement for this low class of diseases to intrude themselves" (Chisolm, p. 198). Treatment included applications of tincture of iodine, saturnine lotions, quinine, tincture of iron, chlorate of potash, laxatives, and cathartics. Pus-filled vesicles were lanced and, as with present-day therapy, the importance of rest and a good diet was recognized.

Hospital gangrene. In his *Practical Treatise on Military Surgery*, Dr. Frank Hastings Hamilton taught:

> The causes of possible gangrene are, overcrowding of patients in confined and filthy apartments, the congregating of men in ill-ventilated barracks, encamping vast multitudes in too narrow limits, and where the winds do not have free access to all the tents, bad or in-nutritious food, stimulating drinks, great loss of blood, the shock of a severe injury, a scorbutic state of the system, insufficient attention to cleanliness and to the dressing of wounds, mental depression, acrid and irritating applications, motion or mechanical irritation, hot and moist climate, exposure to a cold and damp atmosphere, specific contagion.

As with erysipelas, hospital gangrene's infectious and contagious nature was recognized by Civil War physicians. Hamilton wrote: "Its infectious character is so active that when once it has made its appearance in an apartment, nothing but the complete removal of the affected, followed by the most thorough and searching cleansing and ventilation will suffice for its arrest" (p. 193). In 1861, the Sanitary Commission also published literature espousing that hospital gangrene was both contagious and infectious, a lesson learned by the British Medical Corps during the Crimean War. It is notable that a number of Confederate surgeons were precocious with their suspicion that hospital gangrene may have been spread by flies. The theory that flies are a vector in transmitting disease was not formally postulated or understood until well after the germ theory of disease was generally accepted.

Hospital gangrene usually arose as a vesicle or a dark spot on a stump or wound and quickly progressed to ulceration and sloughing of "integuments, muscles, tendons, fascia and finally the arteries, yielding unresistingly to its ravages" (Hamilton, p. 194). Treatments were as varied as were theories of its cause. French and German military surgeons preferred the application of cautery irons to check the advance of the disease. Physicians such as Hennen, Boggie, Baird, Ballingall, and others regarded bleeding as an effective treatment. The most popular treatment of Civil War surgeons was local applications with or without debride-

ment of necrotic tissue. The most popular local applications were bromine and nitric acid. Available statistics of the period contend that bromine treatment, with a mortality rate of 2.6%, was much more effective than local applications of nitric acid, which had a mortality rate of 61.5%. In comparison, other treatment methods combined yielded a mortality rate of almost 40%.

From 1862 to 1864, major outbreaks of hospital gangrene occurred in both Union and Confederate hospital camps. Thereafter, the immediate isolation of hospital gangrene cases combined with general sanitary precautions (i.e., providing the affected patient with his own individual sponge, eating utensils, and toileting necessities, as well as isolating, discarding, or burning infected dressings) resulted in no major outbreaks of hospital gangrene in either Union or Confederate hospitals by 1865. Advocated by Dr. W.W. Keen, the above measures were implemented by him at his hospital in Philadelphia. Although effective, the measures were still not accepted as standards of care by all surgeons, even by the end of the war.

The hospital gangrene familiar to Civil War surgeons may have been a distinct entity from the gas gangrene of today. It has been postulated that the tissue necrosis was caused by either claudication of blood circulation or by a bacterial infection. It appears that the great majority of cases were bacterial in nature, with a streptococcal strain being the most likely infecting organism. More recent theories have equated Civil War hospital gangrene with the necrotizing fasciitis of present times.

Pyemia. As known to Civil War surgeons, pyemia included both septicemia (infection of the blood stream) and pyemia itself (septicemia accompanied by abscesses). In his handbook of military surgery published in 1861, Chisolm declared, "Pyemia, a disease very common in Europe and a scourge of their military hospitals, is a disease, but little known among us, and therefore, not likely to attack our wounded" (pp. 201-202). His prediction in the first year of the war unfortunately was wrong; the dreaded condition struck over 2800 men with a mortality rate of nearly 98%.

In his *Manual of Military Surgery* published two years later, Samuel Preston Moore, M.D., Surgeon General of the Confederate States Army, clarified the issue with the statistics that pyemia was the cause of death in 43% of all fatal primary amputations and in 25% of all fatal secondary amputations and that generally 10% of all amputations terminated in death from this condition. He added, "No means, whether prophylactic or curative, general or local, which afforded a prospect of benefit, have been overlooked, and yet, its mortality is fearfully great" (p. 27).

Dr. Gross taught, "It usually comes on within from three to eight days after the injury, and is nearly always fatal. Its characteristic symptoms are rigors, followed by copious sweats, rapid failure of the vital powers, delirium, and a withered appearance of the countenance, frequently conjoined with an ictorode tinge of the eye and skin" (p. 94).

Medical authors of the day realized that pyemia was a preventable condition. Chisolm taught, "Our great remedy lies in prevention, the hygienic precautions of rigid cleanliness, thorough ventilation, good food, and proper shelter, without overcrowding, will, if properly insisted upon by the medical superintendent, go far to keep away, if they do not altogether prevent the occurrence of pyemia" (p. 207). In a similar vein, Moore taught that pyemia could be prevented by "observing scrupulous cleanliness about the person and apartment of the patient. The room should be freely ventilated, and the wound carefully washed and dressed as often as its condition requires; and in doing this, avoid the use of sponges as the most prolific source of contagion known to the hospital surgeon" (p. 28). Moore's suggestion was astute; at the time his treatise was published in 1863, it was routine to cleanse each wound on the ward with the same sponge and water basin.

Published treatment regimens for pyemia were varied and almost universally ineffective. A nutritious diet was thought to be paramount. It was suggested that patients be exposed to as much fresh air as possible. Opium and liquor were used freely in attempts to allay pain, restlessness, and delirium. The same tonics used to treat erysipelas also were given to soldiers struck with pyemia; local remedies included preparations of silver nitrate, zinc chloride, and perchloride of iron. Cautery was used by some surgeons, but there was some dispute about whether secondary abscesses should be drained. Moore taught that "when secondary abscesses present themselves, they should be freely opened" (p. 29). Chisolm, on the other hand, was more cautious: "The abscesses which form during the march of the disease, should not be too hastily opened, as this course will induce rapid prostration" (p. 210).

Larval therapy

Surgeons of the Napoleonic Wars used maggots to remove devitalized tissue from war wounds and stumps. The lesson apparently was all but forgotten by Union surgeons, who generally considered maggots a scourge and resorted to local applications of turpentine, calomel, or chloroform in an attempt to exterminate them. Confederate surgeons, however, whose bandage supplies were often short, were forced to leave their patients' wounds undressed and exposed to

flies. Many Confederate physicians did recognize the cleansing and scavenging abilities of maggots and actually looked on with satisfaction when a wound or stump was infested, since maggots only consumed dead or devitalized tissue and usually left the wound clean. It is noteworthy that larval therapy was revived during World War I when fly larvae were specifically bred for application in cases of osteomyelitis.

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One of the best known forts in America today, Fort McHenry is nationally renowned as the birthplace of "The Star-Spangled Banner," written by Francis Scott Key during the War of 1812. During the Civil War, however, Fort McHenry became known to Marylanders as the "American Bastille" for its dual use as a federal garrison in defending Baltimore and as a temporary prison for political and Confederate prisoners of war.

Like other sites in the city it protected, Fort McHenry saw use as a federal hospital following the Battle of Antietam in September 1862 and the Battle of Gettysburg in 1863. The wounded were first treated at battlefield hospitals, then moved to the nearest rail depot for transportation to Baltimore, where they were taken to one of eighteen known hospitals or to Fort McHenry's post medical facilities.

The Post Hospital at Fort McHenry was a two-story brick structure with fifty beds. Particularly following the Battle of Antietam, tents were erected on the fort grounds to handle the overflow of patients. The small medical staff consisted of post medical director Dr. Nathan S. Jarvis; post surgeon Dr. James H. Curry of the U.S. Volunteers; and two hospital stewards, Joseph Keigler and S.H. Day. Although more than 20,000 Confederate soldiers (wounded or unwounded) passed through Fort McHenry during the war, only 38 deaths were recorded, of which three were military executions. The post hospital was replaced in 1895.

Other Baltimore hospitals used during the Civil War were

- Wests Buildings, which consisted of six converted tobacco warehouses along Union Dock on Pratt Street;
- Patterson Park Hospital, a 1300-bed facility within the confines of Fort No. 12 in east Baltimore;
- U.S. Marine Hospital, located in Fairfield across the river from Fort McHenry; and
- U.S. General Hospital Jarvis, a 1500-bed facility at Baltimore and Monroe streets.

SCOTT S. SHEADS

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Those interested in learning more about Civil War medicine may wish to contact Burton K. Kummerow, executive director of the National Museum of Civil War Medicine, 48 East Patrick Street, P.O. Box 470, Frederick, MD 21705-0470; tel: 301-695-1864.

Geriatrics for the Clinician

NUTRITION IN OLD AGE

Primary care physicians play a pivotal role in preventing and treating under-nutrition and improving nutrition prior to and during old age. Physicians, however, frequently fail to recognize the role of nutritional factors as causes, contributors, and sequelae of many illnesses seen among the elderly. The goals of nutritional assessment and intervention are to maintain or improve nutrition; to assess, prevent, and treat deficiencies; and to use physiologically efficient, cost-effective, and ethical methods of feeding.

Risk factors for under-nutrition

Elderly Americans are the most rapidly growing segment of the population. There are currently 32 million Americans over age 65, and about 35% live below the poverty line. They may become at risk for under-nutrition when new medical conditions result in functional, physical, or social declines. Thus, accessibility, transportation, and affordability of food are risk factors for under-nutrition among the elderly.

Multiple disabilities are more likely with advanced age. About 5 million elderly people need help with activities of daily living, such as feeding, shopping, and cooking. The disabled elderly may be at risk for malnutrition because of loneliness, depression, monotonous meals, decreased activity, a cycle of anorexia and poor intake, and the unavailability of a care giver to help.

Four out of five elderly persons have at least one chronic medical condition; 35% have three or more chronic conditions. The average older person takes 3 to 12 prescription drugs per year. Drug-drug and drug-nutrient interactions and the anorexogenic properties of some medications (e.g., digoxin, theophylline, iron preparations) may result in under-nutrition.[1]

The elderly account for 40% of all hospital days. Acute illness, functional sequelae of illness, inadequate staffing, surgery, invasive testing, and palatability of hospital food are risk factors for malnutrition among hospitalized elderly persons.

Although only about 5% of those over age 65 do not live at home, 20% of those over age 85 are institutionalized. There is a high prevalence of cognitive and functional disability among the institutionalized elderly. It takes about 45 minutes of personnel time to assist one feeding-dependent patient (40% of institutionalized patients). These patients are at high risk for under-nutrition because of intercurrent disease, the unpalatability of supplements, textured or therapeutic diets, and assisted feeding.[2]

Age-related changes and malnutrition

Several age-related changes place the elderly at increased risk for malnutrition (**Table 1**). Total energy requirements decline from 2700 kcal/day at age 30 to 2100 kcal/day at age 80. A reduction in resting metabolic rate accounts for 15% to 30% of the decline; reduction in lean body mass accounts for 20%; and inactivity accounts for 60%. Total body fat content increases with age (15 kg to 24 kg from age 20 to 80). Protein requirements also increase with age because of declines in stores, reduced hepatic production of somatic proteins, and loss of muscle mass.

Prevalence of malnutrition

Among community-dwelling elderly persons, 20% consume under 1000 kcal/day, 15% have lost more than 5% of body weight in a given year, and 5% have overt malnutrition. It is estimated that 17% to 65% of hospitalized elderly persons are undernourished.[3] Similar prevalences (26% to 59%) have been reported in those living in long-stay institutions.[4] By contrast, 30% to 35% of older persons are moderately or severely overweight, and their food intake is often significantly excessive relative to energy expenditure.

Assessment

History and physical examination. The history should include questions about weight loss, change of taste or smell, abdominal pain, decreased appe-

tite, nausea, vomiting, diarrhea, constipation, dysphagia, problems with chewing or dentures, altered mental status, and other disease states. Asking the patient for a 24-hour or 3-day dietary recall or calorie count may be useful.[5] A medication history may help identify drugs with anorexogenic effects. A social history should inquire about cooking facilities, accessibility, income, and the availability of a care giver.

The physical examination should include specific height and weight measures, which may be compared to standardized tables.[6] Particular attention should be given to the oropharynx and the musculoskeletal and central nervous systems. A bedside evaluation or a modified barium swallow study may provide information about swallowing function.

Anthropometric evaluation is useful if done serially, but age-related changes may limit precision.[7] Triceps or subscapular skin fold thickness approximates adipose mass. Mid-arm muscle circumference and calculations of creatinine-height index also may be useful. Tibial length or arm span can be used for bedridden patients. Body mass index (BMI = weight/height^2) is an accurate measure of obesity.

Biochemical measures can quantify degrees of under-nutrition.[8] Visceral protein levels (albumin and transferrin), iron status, immune competence (lymphocyte count), and vitamin and mineral assays can be obtained. Mortality is significantly increased for patients with albumin levels less than 3 g/dl, cholesterol less than 160 mg/dl, and lymphocyte counts less than 1500/mm^3.[9]

Table 1. Age- and disease-related changes that predispose to malnutrition

Oral cavity
- epithelial thinning
- periodontal disease
- dentin, enamel wearing
- pulp space shrinkage
- candidiasis

Esophagus
- subtle neuromotor slowing
- slower peristalsis

Stomach
- atrophic gastritis
- reduced intrinsic factor production
- reduced gastric acid production

Colon
- villus atrophy
- colonic mucosal atrophy
- reduced lactase production

Other
- decreased number of olfactory glomeruli
- decreased number of taste buds
- lower thirst response
- reduced ADH response to hyperosmolarity
- reduced renal diluting capacity
- decreased neurotransmitter feeding drive
- increased endogenous opioid-dynorphin
- systemic persistence of satiety peptides (cholecystokinin)

Nutritional interventions

All elderly patients should be counseled about nutritious foods and healthful food preparation.[10] Community-based resources such as Meals on Wheels and congregate eating programs are available. A goal of achieving and maintaining ideal body weight is reasonable. A daily caloric intake of 35 kcal/kg should arrest weight loss. Less than 30% of calories should come from fat and less than 10% from saturated fat. Less than 300 mg of cholesterol and less than 4 g of salt should be ingested per day. At least 1500 mg of calcium is necessary to attenuate loss of bone density. More food may be provided by liberating dietary restrictions,[11] giving attention to the feeding process (staff, time, and patience), enhancing the mealtime environment, and providing for food preferences.[12]

Liquid nutritional supplements include puddings, milkshakes, and lactose-free nutritionally complete formulae (Sustacal, Isocal, Ensure), which

provide 1 kcal/ml and 8 g of protein per 240 cc. HN-preparations are available that provide 10 g of protein per can. Nutritionally complete formulae containing lactose include Carnation Instant Breakfast and the soybean preparation Promod, which contains 5 g of protein per scoop. Patients should be weighed every three days and frequent measures of calorie intake conducted. Serum markers such as prealbumin or somatomedin-C can be used to quantify nutritional balance and may be better markers than serum albumin, which has a half-life of 21 days. For patients who resist increasing nutritional intake, other interventions may be tried. Oral hypoglycemics may increase appetite by stimulating insulin release. Growth hormone,[13] cypro-heptadine, chlorpromazine, medroxypro-gesterone, or megestrol acetate are also appetite stimulants.

Although vitamin and mineral supplementation is unnecessary if a normal diet is ingested, supplements are widely used by older adults. The nutrients most likely to be deficient (zinc, potassium, folic acid, vitamin B_6), however, are rarely supplemented. Supplements are expensive and may induce a false sense of nutritional security. There also is some risk of adverse effects, toxicity, and interference with drug absorption.

Table 2. Nutritional formulae*

Milk-based
- Meritene
- Carnation Instant Breakfast
- Sustagen

Lactose-free (1.5-2 kcal/ml, hyperosmolar)
- Sustacal
- Ensure
- Magnacal
- Travasorb

Lactose-free (1 kcal/ml, iso-osmolar)
- Isocal
- Osmolite
- Compleat Modified

Lactose-free; elemental (1 kcal/ml, hyperosmolar)
- Travasorb
- Flexical
- Vivonex
- Vivonex-HCN

* Modified from Morley JE, Silver AJ, Fiatarone M, Mooradian AD. UCLA geriatric grand rounds: nutrition and the elderly. *J Am Geriatr Soc* 1986;34:828.

Tube feedings

For patients unable to maintain adequate oral intake, nutrition may be provided by nasogastric, gastrostomy, or jejunostomy feeding tubes. Before tube feeding is started, the intended outcomes and goals must be considered, particularly in potentially futile medical states.[14,15] If possible, patient and family wishes and durable power of attorney documents should be reviewed.

Percutaneous endoscopic gastrostomy is the most popular route of tube feeding due to the ease of tube placement and few complications. Eighteen-hour infusions of formulae (**Table 2**) are associated with less gastric residuals than 24-hour or bolus feedings. To maintain weight, 30 to 35 kcal/kg of ideal body weight should be provided per day; if weight gain is a goal, 40 to 45 kcal/kg may be required. Activity, stress, and "injury factors" may further increase calorie needs. At least 1500 ml of water/fluid should be provided per day.[16]

Daily fiber intake may be maintained by using fiber-replete formulae such as Jevity, Sustacal with Fiber, Compleat/Modified, or Enrich. For fiber-intolerant patients, isotonic-HN formulae (Osmolite-HN, Isocal-HN) may be more suitable. Formulae should be started at half-strength and at a low rate of infusion. The concentration should be increased slowly, followed by increasing volume. Gastric residuals should be checked hourly and maintained at less than the hourly flow rate. Bolus feeding may be indicated for disoriented patients or when staffing issues are a concern.[17] Elemental preparations provide essential and branch-chain amino acids for patients with renal and liver failure.

Tube feedings are well tolerated with few complications, which may include nasopharyngeal in-

jury, tube misplacement or coiling, reflux, aspiration, bleeding, or leakage. Tolerance to supplements may occur. Tolerance symptoms (diarrhea, nausea, bloating, cramping) usually can be alleviated by reducing the rate or concentration of the formula, although in some cases it may be necessary to change to another preparation. Hyperglycemia, dehydration, hyperkalemia, and hyponatremia also may occur.[18]

Parenteral nutrition

During periods of surgical stress, trauma, or prolonged periods when nothing can be taken orally, parenteral nutritional support may be necessary. Peripheral intravenous nutrition can deliver up to 2 liters of 4.25% amino acid solution with 10% glucose, but these high concentration solutions are irritating to veins and there is a risk of phlebitis. Two liters of the preparation provides 1500 kcal and 10 g of nitrogen; vitamins, minerals, and elements can be added. Parenteral feeding also can be used to supplement enteral feedings. Central venous nutrition (TPN) provides complete nutritional support. A typical solution of 25% glucose and 5% amino acids provides 2000 to 2400 kcal/day. Supplemental calcium gluconate, magnesium sulfate, potassium chloride, sodium chloride, and vitamins must be provided. A 10% lipid solution of 500 ml should be added 2 to 3 times per week.

Complications of TPN include infection, sepsis, trauma or bleeding, liver disease, metabolic bone disease, and fatty acid and trace metal deficiencies. Other frequently noted complications are fluid overload, dehydration, respiratory failure, hypophosphatemia, azotemia, hyper- or hypoglycemia, hyper- or hypokalemia, hyper- or hyponatremia, and hyper- or hypocalcemia.

Conclusion

Intense nutritional assessment and support are justified in any situation of potential reversibility, because they may improve the quality of life for older persons, particularly during dependency. It is important to prepare for older age by being well nourished and to maintain a good level of nutrition throughout old age. The primary care physician must be vigilantly mindful of the central role of reasonable nutrition in good health among the elderly.

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American Medical Association guidelines suggest that physicians ask their elderly patients about family violence, even if a patient does not exhibit signs of neglect or abuse.[1] As the authors of a recent *New England Journal of Medicine* review article on elder abuse[2] point out, however, a literature search of core medical journals produced only 26 articles on elder abuse, compared to 248 reports on child abuse during the same five-year period. Noting that wide variation in the definitions of abuse and neglect of the elderly hinders epidemiologic investigation, the authors nevertheless identify risk factors for abuse based on empirical evidence. These include

- functional and/or cognitive impairment;
- social isolation;
- living with another person who
  - has a history of violence (e.g., an abusive spouse)
  - has a mental illness or substance abuse problem
  - is dependent on the elderly person (e.g., an adult child).

Among elderly patients with adequate resources and a designated care giver, presentations that should alert clinicians to the possibility of abuse include

- poor explanations of physical injuries (e.g., bruises, lacerations, head trauma, fractures);
- malnutrition and dehydration;
- frequent exacerbations of chronic disease.

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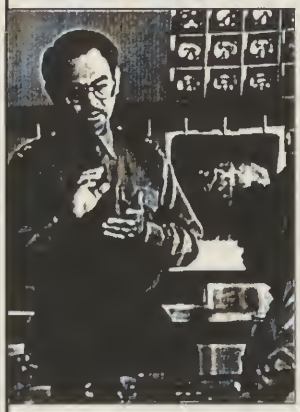
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Imaging Case of the Month

Fibroxanthomatous Infiltration of the Achilles Tendon

A 41-year-old woman sought medical attention because of a nonpainful mass in the region of the Achilles tendon. Physical examination showed nontender, nonmobile, firm enlargement of the Achilles tendon. A lateral radiograph (**Figure 1**) demonstrated nonspecific soft tissue thickening in the Achilles tendon region. The patient was referred for a magnetic resonance image (MRI) of the ankle to evaluate the possibility of a soft tissue mass. A sagittal T1-weighted MRI showed massive diffuse enlargement of the Achilles tendon (**Figure 2**). An axial T1-weighted scan also showed thickening of the tibialis posterior and peroneus longus tendons (**Figure 3**).



Figure 1. Lateral radiograph of the ankle shows nonspecific soft tissue thickening (arrowheads) in the region of the Achilles tendon.



Figure 2. Sagittal T1-weighted MRI of the ankle shows massive enlargement of the Achilles tendon (arrowheads).



Figure 3. On the axial T1-weighted image, the enlarged Achilles tendon is identified in cross-section (arrowheads) and thickening of the tibialis posterior tendon (arrow) is also observed.

At age 17, the patient had undergone an excision of a mass involving an extensor tendon of the right forearm and biopsies of a finger tendon and both Achilles tendons. At the time of surgery, the Achilles tendons were described as appearing diffusely infiltrated with cholesterol. The pathologic tendon specimens appeared saturated with histiocytes and occasional giant cells compatible with xanthomatous tendon infiltration.

Discussion

Tendon xanthomas represent a manifestation of familial hypercholesterolemia, an autosomal dominant condition associated with elevated serum low density lipoprotein and increased risk for arteriosclerosis and cardiac ischemia.[1] Although xanthomatous infiltration of tendons may be observed in other disorders of lipid metabolism, the association of hypercholesterolemia is of particular clinical relevance because tendon enlargement may represent the first clinical manifestation of the disease.[2]

Pathologic examination of a tendon specimen shows that tendon xanthomas consist of a mixture of normal tendon collagen tissue and abnormal histiocytes that contain cholesterol, cholesterol esters, triglycerides, and phospholipids.[3] Although experimental evidence suggests that triglyceride-predominant xanthomas may appear hyperintense on MRI, most xanthomas manifest low signal intensity, approximating the appearance of normal tendon except for size.[1,4]

Because tendon enlargement may represent the initial clinical manifestation of familial hypercholesterolemia, recognition of the abnormality and its association with accelerated heart disease is critical to appropriate clinical intervention.

The patient presented in this case report successfully maintained her cholesterol level within normal limits through dietary modification.

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ROBERT VAN BESIEN, M.D.
Editor ■

PHYSICIAN AUTHORS WANTED

"Imaging Case of the Month" is a regular feature of the Maryland Medical Journal. *Coordinated by the Maryland Radiological Society, the cases presented provide a review of a broad range of diseases and pathological processes of interest to a wide range of specialists.*

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1955:

- *Churchill resigns; Anthony Eden becomes prime minister*
- *Naabokov publishes* Lolita
- *"Rock Around the Clock" is a hit single*
- *Frederick Sanger determines the molecular structure of insulin*
- *Nashua wins the Preakness and Belmont*
- *Canada cuts income taxes, increasing national debt in the interest of national prosperity*

The Shock Therapies

Excerpted from the *Maryland State Medical Journal* 1955;4(3):128–135.

John D. Patton, M.D.
Dr. Patton was the clinical director of the Sheppard and Enoch Pratt Hospital in Towson, Maryland.

One of the major advances in psychiatric therapeutics was made with the discovery of the so-called "shock therapies." In the almost twenty years that have followed, the psychiatric literature has contained many confusing and controversial reports pertaining to these forms of treatment.

ECT [electroconvulsive therapy] is the use of an electrical current to produce a convulsion. ICT [insulin coma therapy] is the use of insulin to induce hypoglycemic comas. It is clear that these forms of treatment are a most valuable adjunct in the treatment of psychotic states. It is still unclear how these treatments achieve their effectiveness, but it does seem that they are operative at a symptomatic level rather than at an etiological level.

The best clinical results with ECT have been noted in patients with depressive symptomatology. ICT seems to be of value in the treatment of the schizophrenic reactions. The use of these forms of treatment has resulted in increased rates of remission and shortened hospitalizations.

Experience has continued to show that ICT can be effective in the treatment of schizophrenic reactions. The results in schizophrenic reactions treated with ECT have been poor. However, ECT has been found to be effective in the treatment of affective (depressed or agitated) reactions. ECT does not prevent subsequent attacks, nor does it alter the

frequency of the depressive episodes. In depressions associated with organic brain disease, such as that found with senility and cerebral arteriosclerosis, ECT may be of benefit in alleviating the depressive symptomatology. In manic depressive psychosis, manic type, the manic episode may be shortened by the use of ECT. As with manic depressive reactions, depressed type, ECT does not prevent subsequent attacks nor does it alter the frequency of the recurrence of manic episodes.

In schizophrenic reactions, where affective elements are present to a large degree, ECT may relieve the affective symptomatology. ECT may be of value as sedation in the management of chronic excited patients. The most common use of ECT with schizophrenic reactions, and one of its greatest values, is to achieve sedation in extremely excited patients who are in danger of exhaustion through a combination of poor physical health and overactivity. Here ECT may prove to be a life-saving measure. On the other hand, the use of ICT with schizophrenic reactions seems to increase the recovery rates, although it does not prevent relapse or recurrence of the reaction. In patients who do maintain their recovery, the span of hospitalization is frequently shortened.

In psychoneurotic reactions, psychophysiological reactions (psychosomatic states) and personality disorders (behavior disorders), neither ECT nor ICT have proved to be of value. One possible exception is in the treatment of psychoneurotic reaction, depressed type (reactive depression). If these reactions have remained refractory to other treatment, and there is a marked suicidal risk, ECT may help the patient to achieve a satisfactory recovery.

There have been many attempts to correlate clinical observations and various test results with prognostic signs. The search has been for certain positive findings which may point out specific indications for ECT or ICT. However, any prognostic sign or test which indicates favorable recovery, means that the patient will probably recover, no matter what the treatment is. As yet there is nothing which will point up specific indications for ECT or ICT.

ICT must always be administered in a special unit in a hospital setting. The amount of insulin required to induce a hypoglycemic coma varies from patient to patient. Initially the doses are quite low and are gradually increased to the point where the patient has a hypoglycemic response and then the doses are adjusted to the patient's reaction. In hypoglycemic coma, various stages or levels of symptoms occur in regular fashion according to the level of central nervous system inhibition. At the stage of beginning medullary inhibition comas are promptly terminated. If complications arise at an earlier stage, comas are always promptly terminated.

The major problem is the termination of the coma which persists after the termination of the hypoglycemia. The so-called irreversible coma, or prolonged stupor, is a major problem which may end in death. Patients in whom there is any evidence of apparent possibility of cardiac difficulty should not be treated. A course of treatment usually consists of induction of coma five days a week for an average period of ten weeks. Some patients receive more treatment and some less, depending upon the patient's individual response.

In recent years there has developed a tendency to combine ECT with a course of ICT. A course of about ten ECT are given over a period of two or three weeks near the end of a course of ICT. The ECT is given while the patient is in a "light" stage of coma.

The aim and technique of ECT is quite different. An ECT machine is simply an electronic timer which is supplied with alternating current from an ordinary house circuit. In the standard technique, voltage may be varied from 50 to 150 and the time of current flow from a tenth of a second to one second. Usually 120 volts for 0.5 second will satisfactorily produce a convulsion. The electrodes are placed bilaterally on the patient's temples in the fronto-parietal region. Treatment is usually given in the morning, three times a week. In manic or excited states, several treatments may be given each day. After a patient improves, the frequency of treatment is diminished. The number of treatments necessary to achieve remission is variable; it may be as low as one or as high as 30, but usually about 10 treatments is sufficient.

The unpleasant side-effects and complications are grossly of two types, psychological and physical. Among the psychological complications there is a relative amnesia. However, the amnesia is usually minimal and reversible.

The most frequent complications seen are the vertebral fractures which usually occur with the first treatment. It does not seem possible to predict, nor absolutely to prevent, these fractures which are, for the most part, asymptomatic. The commonly accepted incidence of vertebral fracture with ECT is about 20%. These fractures do not necessarily prevent continued treatment. After a two or three week interval, treatment can be re-started if it seems psychiatrically indicated. In such instances, muscle relaxants are frequently used. Fractures of the long bones occur extremely rarely.

With ECT the usual reported fatality rate is about one-tenth of 1% of the patients treated. The reported fatality rates with ICT may range from about a half of one percent to one and one half percent. It appears that there are no absolute physical contraindications to ECT.

It still remains unclear how ECT or ICT achieve their therapeutic effect. There are certain physiologic changes that do occur with both forms of treatment. Patients often report experiencing "a death threat," or "dying and coming alive." It may well be that the word "shock" is appropriate in that we frighten or scare our patients back to normalcy. ECT or ICT, although they may break up or interrupt maladaptive responses to stress, do not solve the problem of why this particular person, with this particular life history, has reacted in this particular way to this particular life situation.

Unfortunately, trends in the direction of prompt, immediate treatment with ECT or ICT have developed, to the exclusion of a more rational, comprehensive plan. The trend in this direction has resulted from the very natural desire to alleviate human suffering as promptly as possible and to obviate the emotional, social and economic distress of more prolonged treatment, perhaps in a psychiatric hospital. Another influence is that many people can only conceive of treatment in terms of "doing something" of a physical nature. Irrational prejudices often manifest themselves against any approach or treatment where a visible cause and effect relationship cannot be immediately and visibly demonstrated. Such prejudices are rationalized with the statement that "nothing is being done" or that the doctor and patient are indulging in a "luxury," or that such efforts are "a waste of time."

It must be stressed that even the most ardent ICT-ECT enthusiasts state that patients who recover without "shock therapy" seem to make better recoveries with less likelihood of relapse. In other words, the recovery of non-shock treated patients seems to be of a better quality. In dealing with psychiatric problems, treatment does consume a great deal of time and is slow and tedious. However, one of the most important therapeutic attitudes toward psychiatric patients is that of patience, so that the sick person has enough time to make their necessary readjustments.

For some years, about 20% of the admissions to the Sheppard and Enoch Pratt Hospital have been treated elsewhere with ICT and/or ECT. Prior to coming to Sheppard Pratt these patients were treated with the appearance of the first signs of emotional disturbance. In the treatment of these ICT and ECT failures, a slower, less drastic approach frequently leads to remarkable recoveries.

There seems to be a proper time and an improper time to administer ECT or ICT. If ECT or ICT are at all indicated, they will achieve an optimal effect if applied when the patient is ready to "give up" his maladaptive reaction but is unable to do so because he is "out on a limb" or caught in a "vicious circle."

Even the most ardent ECT-ICT enthusiast will state that ICT-ECT treated patients should also be treated psychotherapeutically. However, it must be realized that the shock therapies make the usually difficult task of psychotherapy infinitely more difficult. These treatments mobilize so much fear and anxiety that a therapist's efforts have to be mainly directed at handling the treatment-generated fear. Shock treatments also result in confusion and forgetfulness that may make collaborative investigative efforts impossible. Furthermore, with ECT and/or ICT, there results a repression, or constriction of mental content that hampers psychotherapeutic efforts. In connection with this, it does seem that patients treated with ECT or ICT are "conditioned" to handle conflictual situations by repressing or forgetting the situations, the issue involved and the alternative responses. This results in a frequent observation that patients seem rigid and stereotyped, with a seeming loss in adaptive capacity. In consequence of the above mentioned factors, the majority of the reports that deal with the psychotherapy of ICT or ECT treated patients, suggest a supportive, non-investigative type of approach. However, with skillful management, many people believe that considerably more can be done with these patients. Frequently ICT or ECT seems to facilitate the removal of affective or intellectual barriers which impede the psychotherapy of psychotic reactions. It is suggested here that intensive psychotherapy and shock therapy are not of necessity mutually exclusive, as is usually claimed, but there may be instances where they are.

Case I. A man in his early fifties was admitted to the Sheppard and Enoch Pratt Hospital as a transfer from a general hospital. He had been admitted to the general hospital for an emergency abdominal operation. In the course of uneventful convalescence, he became disturbed emotionally. This progressed to a full-blown manic excitement. Twenty years previously he had had a similar excitement without any apparent precipitating stress. Then he was treated in a psychiatric hospital for about two months and recovered without ensuing difficulty.

At the time of his admission to Sheppard Pratt, physical examination and laboratory studies revealed no other findings than those incidental to his operation from which he was recovering. Within 72 hours, the patient became stuporous, refused all food and required seclusion. In the seclusion room he rolled about and became combative at the approach of personnel. He was unresponsive to any of the various modalities of management. Tube feedings became necessary. In the next several days the patient developed a gluteal abscess and began to show ankle edema. Laboratory studies indicated dehydration and a beginning uremic state. It was decided to begin the patient on ECT. Following the first treatment he began to eat. After the second treatment he began to talk and it was possible to remove him from seclusion. After the fourth treatment he presented physical symptoms and findings suggestive of a thrombophlebitis, and ECT was stopped. In the next two weeks on combined medical and psychiatric treatment, all signs of physical and mental distress abated. The patient continued to convalesce over a four week period. During this time he gradually took part in all hospital activities. At the end of six weeks he was discharged as recovered and has continued to do well.

Case II. A 20-year-old university student became markedly disturbed with acute schizophrenic excitement. He was admitted to Sheppard Pratt and required treatment in the disturbed unit. Past history revealed that over the previous three years he had shown a gradual change in behavior and there had been several short-lived, acute schizophrenic episodes. His excitement abated over the course of one month and he was able to move to a semi-convalescent unit. However, he remained apathetic, withdrawn and preoccupied, with many autistic fantasies. It seemed that he was headed for a lengthy hospitalization with a doubtful outcome.

Over the next three months the patient received approximately 50 ICT and showed typical improvement. His apathy improved and he became more a part of the hospital community. He talked at great length with his doctor about his fantasies and they, and his disturbed behavior, became understandable as ways of dealing with many feelings of inadequacy and inferiority. The major theme of his life seemed to be a competitive struggle to match the success of his father and several older brothers.

Following the termination of his ICT he moved to an open hall and gradually resumed the full responsibility for the direction of his life. He formulated more realistic plans for his future, both socially and vocationally. Following his discharge from the hospital, he continued to do well and according to reports from both the patient and his family, he seems to be happier and healthier.

Case III. A married woman in her early 60's was admitted to Sheppard Pratt in a depression that seemed to be precipitated by the combined emotional and physical problems of growing old. She expressed many nihilistic ideas with many somatic delusions. Prior to her hospitalization she had made a suicidal attempt which narrowly missed succeeding. Following her admission she continued to attempt suicide. She seemed headed for a lengthy hospitalization in which she might succeed in killing herself. She was promptly begun on ECT and in the course of four weeks received ten treatments. During this time, and the month that she remained in the hospital after the termination of ECT, she talked over with her doctor many of her concerns. After a life of devotion to her family, she found herself with little to do and the family uninterested. She also presented a certain loss of intellectual facilities which made it difficult to pursue some of her ordinary interests. During convalescence she developed many new social and avocational interests which seemed to fill some of the void in her life. She has appeared to do well following her discharge.

Case IV. A young man had a schizophrenic reaction at the age of 12 which required hospitalization in the children's division of a psychiatric hospital. At this time he made several uncontrolled, murderous assaults upon various people. He was given a series of 10-15 ECT and made an apparently satisfactory recovery. Much later he reported that he was terrified with the ECT and thought the shock treatments were being used to kill him. However, he reported that the doctor seemed to be a friendly, kindly person who was not at all like an executioner. This perception led the patient to believe that the treatments were probably not designed to kill him and hence he felt reassured.

Later he made a marginal adjustment in the community for about six years. He was able to go on with his schooling in part aided by psychotherapy.

At 18 he had another acutely disturbed psychotic episode. All of his old psychotic ideas and behavior returned and he was rehospitalized in a different hospital. In the course of this reaction he was transferred to a second hospital. In both places he continued to be disturbed and was unresponsive to treatment. As a result, he was given innumerable ECT and

combined ICT-ECT. Throughout this period he remained unimproved. Much later he reported that the doctors who administered these treatments, in both hospitals, acted as if they meant to kill him. They did not seem at all like the warm, friendly doctor of the first admission. The patient also reported that when ECT and ICT were administered, he felt a great deal of sexual stimulation. During the treatments he would become unconscious and frequently had to be made to submit to the treatment through force. Because of these facts, he concluded that he was being sexually assaulted during the treatment. He remained unimproved and finally the hospital informed his mother that she would have to consent to a pre-frontal lobotomy or remove the patient from the hospital. At this point she arranged his admission to Sheppard Pratt. This was after a period of two years of continuous hospitalization.

At Sheppard Pratt the patient remained disturbed and assaultive but no ICT or ECT was administered. His disturbed behavior resulted in his injuring himself. He was given large doses of chemical sedation over a period of several weeks. While sedated he was put to bed and given a great deal of "special attention." Although helpless, he began to feel, for the first time, that he was not being tortured or murdered. It became possible to discuss with the patient his real life situation which precipitated his psychotic reaction. The patient began to show improvement and his sedation was stopped, after which he had a "spontaneous" seizure. For some months he remained periodically upset with many psychotic ideas and psychotic behavior. However, he had begun to establish interpersonal relationships and as he progressed he was able to move through the convalescent units of the hospital. Six months later he was discharged after having shown considerable progress with a much better degree of integration and much more strength to handle the issues of real life. He has been followed for two and a half years after his discharge and has been treated with intensive psychotherapy. He has progressed to the point of becoming financially self-sufficient and is about to finish his college education. He has reported amnesia for a great many events, claiming he cannot remember them because they occurred during the time of ECT. He finally reported, "You know, doctor, I remember some things from that time and don't remember other things." Some months later his statement was to the effect, "It seems I recall the things I want to remember and don't recall the other things." With this patient it was frequently the "good" things which were forgotten and the "bad" things which were recalled. Still later he said, "It seems I can remember all the things I say I can't remember but it does seem whenever anything upsets me, I just seem to blank out."

Summary

Shock therapies are a valuable adjunct in the total, overall treatment of psychotic reactions. There is no evidence to indicate that they are of benefit in non-psychotic states with the possible exception of psychoneurotic reactions, depressed type, that have not responded to more conservative treatment. The use of these treatments frequently results in an increased rate of recovery with a shortened period of hospitalization. However, there are many complications and unpleasant side-effects. Some attempt is made to show how the "shock therapies" can be integrated into a program of total psychiatric care. ■

Commentary

Reading Patton's article, I was struck both by how much we have learned since then and how ignorant we still are.

Insulin coma therapy has long been abandoned. A lack of controlled studies to demonstrate its effectiveness, its dangerousness, and the advent of the neuroleptics led to the disappearance of ICT as a treatment for schizophrenia.

Electroconvulsive therapy, on the other hand, remains an important therapeutic modality in the treatment of affective disorder. The effectiveness of ECT in depression has been well documented in double-blind, controlled studies comparing it to sham treatment. In addition, advances in the technique and technology of ECT have markedly increased its safety and have virtually eliminated the most problematic side effects described by Patton.

The mortality rate of one death per 1000 patients cited by Patton has been greatly reduced with modern anesthetic techniques that involve adequate oxygenation and monitoring of blood pressure, heart rate, electrocardiogram, and blood oxygen saturation. Current mortality with ECT is less than 3 deaths per 10,000 patients or 2 deaths per 100,000 treatments. The risk of death is no greater than the risk associated with anesthesia from a short-acting barbiturate

alone. Short-acting barbiturates such as methohexital have completely eliminated the terrifying experiences reported by some who received ECT without anesthesia in the early days of its use. Furthermore, the use of succinylcholine to produce muscle relaxation and thus modify the tonic-clonic convulsion, has virtually eliminated the risk of vertebral fracture, which Patton states had an incidence of about 20%!

We also have come a long way in eliminating the problem of memory impairment as a consequence of ECT. The major changes responsible for the improvement are the switch from bilateral to right unilateral electrode placement and the development of modern ECT devices that deliver a high-intensity, brief-pulse stimulus. In fact, with modern ECT techniques and devices, little or no memory disturbance occurs during or after the course of treatment. At six-month follow-up, patients who have been treated with modern ECT have no detectable cognitive impairment and are indistinguishable cognitively from patients who have not received ECT.

Despite these advances, however, we still do not understand how ECT produces its therapeutic effect. And despite these improvements, fear and prejudice about ECT are still quite common.

MARK L. TEITELBAUM, M.D.
Dr. Teitelbaum is an associate professor of psychiatry and medicine at The Johns Hopkins University School of Medicine. ■

A consensus panel of the Functional Brain-Gut Research Group of the American Gastroenterological Association has concluded that all patients with severe or refractory irritable bowel syndrome (IBS) should be asked if they have been victims of physical or sexual abuse. The recommendation is based on data indicating that up to 54% of IBS patients will give such a history.[1]

The Adult Outpatient Psychiatry Clinic at University of Maryland Medical Center offers a therapeutic support group for people with chronic gastrointestinal disorders (e.g., IBS, Crohn's disease, pancreatitis, colitis, ulcers, dyspepsia, dysphagia). For more information, call Hinda Dubin, M.D., 410-328-6565.

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Books, Etc.

Lexicon of Psychiatry, Neurology, and the Neurosciences. Frank J. Ayd, Jr., M.D. Baltimore, MD: Williams & Wilkins; 1995. 741 pages. $50 (paper).

This 741-page lexicon is more than a dictionary. It is an annotated glossary for clinicians who practice in any of the three fields noted in the book's title.

Although the book's scope goes well beyond the usual topics from Dr. Ayd's *International Drug Therapy Newsletter*, it is not the third or fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*. It also is not a psychotherapist's handbook of terms. There are no lists of diagnostic criteria and there is no definition of the word *transference* or other psychodynamic terms. There are the most interesting and informative definitions of the terms *adrenergic* to *tranquilizer* that you are likely to find anywhere. Its great strength is that the definitions are presented via the clinical wisdom of Frank Ayd. Clinicians not fully familiar with new drugs, new tests, and new technologies will find this book indispensable.

The pharmacologic definitions are the most detailed elements of the book. All of the newer (and older) pharmacologic agents used in neurology and psychiatry are described and drug-drug interactions (synergistic and toxic) are also specifically highlighted. Definitions of technical terms used in controlled clinical trials, molecular genetics, and molecular neuroscience research are also amply covered.

The book is substantial in size and in aim. There are some criticisms due to a few words left out and a definition or two with which I do not agree. However, the book succeeds wonderfully. My copy will be at my desk side until it is replaced by a second edition.

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■ ■ ■

Your Vision. All About Modern Eye Care. Warren D. Cross, Jr., and Lawrence Lynn. New York, NY: Mastermedia Limited; 1994. 312 pages. $19.95 (paper).

Disturbances in vision are one of the most common human afflictions. Some pertinent annual statistics of modern eye care in the United States include: 153 million people wearing corrective lenses, 40 million people wearing eyeglasses for reading, 3 million ocular operations, and a half million cataract extractions.

Written in simple, reader-friendly prose, *Your Vision. All About Modern Eye Care* is a well-illustrated, encyclope-

To Our Readers

The Editorial Board of the *Maryland Medical Journal* invites you to submit reviews of books, videos, and films of interest to the medical profession. Bringing your evaluation and analysis to the attention of your colleagues will be informative and stimulating. Send your report to: Chris Papadopoulos, M.D., Book Review Editor, *Maryland Medical Journal*, 1211 Cathedral Street, Baltimore, Maryland 21201.

dic compendium that provides educational information for the general public. It contains 18 chapters, a bibliography, and an index about eye problems. The authors include a capable ophthalmologist, a research engineer, and a number of their colleagues in their eye associate group in Houston, Texas.

The subspecialty of ophthalmology has made great strides in recent years through the acquisition of sophisticated techniques. Physicians and some of the lay public may be cognizant of these changes, but a need exists for people in general to be more informed about these matters. Each section of *Your Vision* is concluded with a unique "wrap-up" in which the significant features are restated clearly.

Refraction, the physics of optics and cataracts, and their treatment are described. The use of lasers and electromagnetic energy in eye surgery is a fascinating chapter about a relatively new field. The subject of glaucoma also is well discussed. Criteria necessary for the diagnosis of elevated intraocular pressure and the methods of treatment by medication or laser surgery are clearly defined.

The section on corneal refractive surgery is outstanding. By altering how light focuses on the retina, this surgical procedure can improve vision in up to 97% of patients. Another well-handled chapter concerns the use of contact lenses. The types of lenses available, recommendations for their use, and accompanying complications are clearly explained.

Infections of the external eye, the selection of eyeglasses, and ophthalmic plastic surgery are the subjects of other chapters. Pertinent to modern living is the section on substance abuse and its effect on the eye.

A chapter on frequently asked questions is most enlightening. A well-structured bibliography and a satisfactory index complete this useful primer. The information contained, the readability, and the inexpensive cost recommend the book to the nonmedical public. A place for it should certainly be found in all public libraries.

JOSEPH M. MILLER, M.D.
Timonium, Maryland

■ ■ ■

"Outbreak"

Imagine a deadly virus destroying an entire African village overnight, and the government's interpretation of surveillance and containment is to fire-bomb the village. Now imagine a mutant strain of the same virus, spread by airborne droplets, loose in a small California town. This sets the stage for the struggle of good versus evil with public health medicine as the backdrop in the science fiction movie "Outbreak."

The film is a fast-paced adventure story of tracking the spread of disease and searching for the host animal and an antiserum under life-and-death time constraints of monumental proportions. A range of emotions is elicited from the audience as the movie puts names and faces on cases of the disease and attributes human emotions to army personnel and doctors from the Centers for Disease Control and Prevention.

The movie shows how "public health exists at the interface of science and politics."[1] It reminds us "to be aware of our own personal values, preconceptions, and biases—our culture—as we approach scientific and public policy questions" and that "matters of democracy, culture, and freedom play important roles in what some described as purely scientific issues."[1] The plot, however, does require physicians to suspend our knowledge of epidemiology in order to accept its faulty portrayal of viral mutation and antiserum production. If we overlook these shortcomings, the movie is exciting and entertaining, and a dramatic illustration of possible dire consequences when universal precautions are ignored.

MARILYN S. RADKE, M.D., M.P.H.
Waldorf, Maryland

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What Your Patients MAY BE READING

- "The Best Medical Specialists"
  Town & Country, March 1995

- "Drop Cholesterol 30 Points"
  Men's Health, March 1995

- "Everyday Medicines That Harm Your Kids"
  Ladies' Home Journal, April 1995

- "Food Allergies: When Eating Causes Pain"
  Black, March/April 1995

- "Puffy Eyes? Weight Gain? The Disease Even Doctors Miss"
  Good Housekeeping, April 1995

- "Psyching Out Insomnia"
  Working Woman, March 1995

- "SIDS: Facts You Must Know"
  Parents, March 1995

- "Cold or Allergy?"
  McCalls, April 1995

- "Just Because You're a Hypochondriac Doesn't Mean You Don't Have a Horrible Disease"
  GQ, March 1995

- "Healing Through Intuition"
  New Woman, March 1995

- "Spot Check. The Latest Treatments for Adult Acne"
  New Woman, March 1995

- "Body & Soul. New Age Health Remedies"
  Mademoiselle, April 1995

- "Health: A User's Guide to the Pill"
  Mademoiselle, April 1995

- "Plastic Surgery Special. Before You Go Under The Knife, Read This!"
  Elle, March 1995

- "The Free Radical Radical"
  Running, March 1995

- "The New Midwives. Can They Deliver a Better Birth?"
  Parenting, April 1995

- "Will Popping Pills Banish Your Blues? The Truth About Prozac and Other Mood Changers"
  Cosmopolitan, March 1995

- "Alcohol, Stress and Black Women"
  Essence, March 1995

- "Medical Chaperones"
  Self, March 1995

- "Ovarian Cancer"
  Self, March 1995

- "The Controversy Over Hepatitis B Vaccination"
  Shape, April 1995

- "Genes That Cause Cancer"
  Scientific American, March 1995

- Health Report by Isadore Rosenfeld, M.D.:
  - Mammography Update
  - Is Tylenol Still Safe?
  - Do Diuretics Affect Your Sex Life?
  - Managing Migraines
  - Relief for Bulimia

  Vogue, March 1995

COMING OUT OF THE DARK

Med Chi's Physician Rehabilitation Committee deals with the substance abuse and mental health problems of Maryland physicians, with a confidential and nondisciplinary focus...Addiction, Marital/Family Conflicts, Psychiatric Illness, Organic Impairment, Physical Handicap...If these problems exist, we can help find the solution. Call us.

The Physician Rehabilitation Committee of Med Chi is available to all Maryland physicians, and their families. The Committee is NONDISCIPLINARY and information is kept CONFIDENTIAL. If you, a colleague, or family member is in need of our services call (410)962-5580 or call toll free (800)992-7010, or leave a message 24 hours a day, 7 days a week at (410)727-1020.

HELPING IS OUR BUSINESS...All donations to the Physician Rehabilitation Committee are used for the delivery of services to Maryland physicians in need of help. If you wish to help further the work of the Committee through a tax deductible donation send your check to: The Medical and Chirurgical Faculty Charitable/Educational Foundation, 1204 Maryland Avenue, Baltimore, Maryland 21201 Please note on your donation: "Physician Rehab"

Medical and Chirurgical Faculty of Maryland

Physician Rehabilitation Committee

Alliance

Mehry Motamen Reid: 1995-1996 Alliance President

The newly elected president of the Med Chi Alliance, Mehry Motamen Reid, was installed along with her fellow officers by Barbara Tippins, president of the American Medical Association Alliance, at the annual meeting of the Med Chi Alliance held at the Turf Valley Country Club on April 7. Mehry is the second member from Frederick County to serve as state president.



Born in Mashhad, Persia (Iran), Mehry is the youngest of eight children. She comes from a family steeped in a tradition of public service; her father served as lieutenant-governor of the Persian province of Khorasan under two monarchs and was mayor of Mashhad; her paternal grandfather served as the Persian ambassador to Afghanistan before his assassination by terrorists; and her eldest sister was national director of the Persian Girl Scouts. All of her family are devotees of art and literature; her father wrote a comprehensive history of Khorasan and her maternal grandfather was an historian, scholar, and poet. Her eldest brother holds a doctorate from the University of London School of Economics and is the author of a number of textbooks on economics. Now retired from that field, he is a successful artist.

Mehry's talent for art became manifest at an early age; she won second prize in a national art contest while a student in the ninth grade. After she completed elementary school in Mashhad, Mehry's family moved to Tehran, where she finished her education. She later became active there in the Federated Garden Clubs and the International Womens' Club. Accredited by Ikebana International as an instructor in the art of Japanese flower arrangement, she appeared on Iranian public television in a one-woman show of her handicraft art and flower arrangements. For that show and other exhibits, she received a number of awards from the queen and prime minister.

Before her permanent entry into the United States, Mehry studied at the universities of Tehran, London, and Los Angeles, majoring in the fine arts. Since becoming a U.S. citizen, she has written and published five books on Persian art and design and a cookbook devoted to Persian cuisine. Her most recent work, a book of her memoirs co-authored with her husband, Dr. Thomas R. Reid (a retired radiologist and past president of the Frederick County Medical Society and Maryland Radiological Society), will be published in the early fall of 1995. Mehry's only daughter, a talented artist with several shows to her credit, lives in Portland, Oregon, with her four-year-old son.

Mehry has lived in Frederick County since her marriage to Dr. Reid in 1978. She is a life member of the Federated Garden Clubs of Maryland and guest lecturer at Frederick Community College on Persian miniature art. Mehry has been an active member of the Alliance to the Frederick County Medical Society since it was organized in 1984; she served a two-year term as president from 1989 to 1991. She became second vice-president of the Med Chi Alliance in 1993, and president-elect in 1994. During her tenure as president-elect, she also served as chairperson of the state membership committee.

During the forthcoming year, Mehry's plans for the Alliance include continuing the fight against domestic violence through education of the public as to the help available to victims of violence and support of those agencies that provide that help. She also plans to encourage the component county alliances to continue to expand their health project activities, especially those

directed toward the education of children regarding drug, alcohol, and tobacco abuse. Recognizing that the future strength of the Alliance depends on the ongoing recruitment of new members and that the preservation of high quality medical care in the nation depends on attracting talented young people to the medical profession, Mehry plans to work closely with the membership and AMA-ERF committees of each county to help them realize their goals.

As a participant in the leadership seminars sponsored by the national AMA Alliance, Mehry was impressed with the benefits to be derived by providing a training program for newly elected officers of the Alliance. She plans to offer a similar program to all of the newly elected county alliance officers in Maryland by inaugurating a one-day seminar patterned after the national Leadership Confluence meeting. The "mini confluence" will be held in September and speakers from the national as well as the state alliances will conduct seminars on the various aspects of leadership and organization.

The all-important issue of health care reform will in all certainty occupy the attention of national and state legislatures during the next year and possibly for years to come. The medical profession must continue to make certain that its voice is heard in the planning and implementation of any health legislation, and to that end, the president pledges her support of the activities of the Legislative Committee of the Alliance and the continuation of close cooperation with Med Chi in its efforts to present the views of the medical community to our legislators. ■

A message of thanks

I must say that when I asked the members in my inauguration speech to impress me, you certainly took me literally. You have proven without a doubt that this group is enthusiastic and willing to go all the way. You have shown me that you are the best. Without your fund-raisers, your concern for the community health, we could not live up to our motto Physicians' spouses dedicated to the health of America.

Without the help of the staff at Med Chi, many projects could not have been done. Thank you, Mary Ann Ayd, for your wise guidance to us for the MMJ; to Virginia Carter in the graphics department—your know-how and patience are most appreciated. And, last but not least, JoAnn Troisi, our girl Friday! Without JoAnn nothing is possible and with JoAnn everything is possible. Thank you all—my board, committee chairs, staff at Med Chi—for making my job this year look so easy and making me look so good!

ADRIANA ZARBIN
Med Chi Alliance president, 1994-1995

MARYLAND

The Alliance always welcomes new members.

Alliance members support the physicians and are recognized for their contributions to health, education, and the promotion of quality health care in Maryland.

For information on becoming a member, call JoAnn Troisi at Med Chi's Alliance office.
539-0872 (Baltimore area)
1-800-492-1056 (toll free in MD)



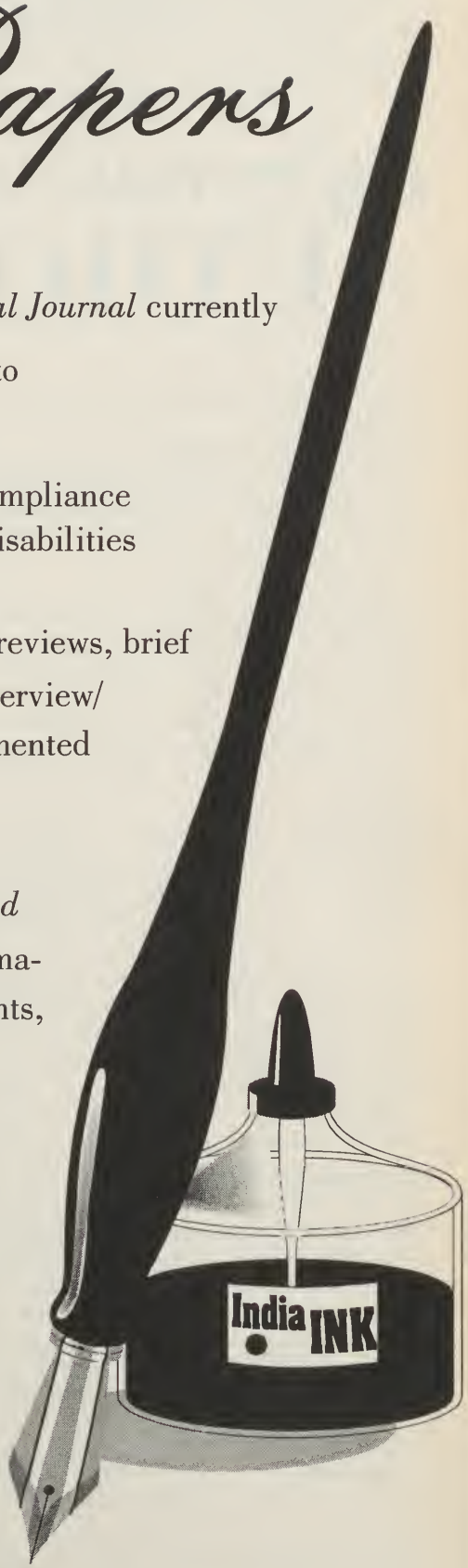
Call for Papers

The Editorial Board of the *Maryland Medical Journal* currently seeks original articles addressing topics related to

- Drug Interactions in the Elderly
- Strategies for Enhancing Therapeutic Compliance
- Assistive Technologies for People with Disabilities

Papers may be original research, literature reviews, brief reports, case histories accompanied by a brief overview/ summary of the relevant literature, or well-documented opinions about future trends.

All submissions should conform to *Maryland Medical Journal* requirements. For further information or to obtain a copy of submission requirements, contact Mary Ann Ayd, Managing Editor,
1211 Cathedral Street, Baltimore, MD 21201;
410-539-0872 or 1-800-492-1056;
FAX 410-547-0915.



The Maryland Medical Journal (MMJ) *is a monthly publication of the Medical and Chirurgical Faculty of Maryland. The journal's goals are educational and informative: the publishing of scientific articles (original research, case studies, and review articles) and other technical information, as well as editorials, letters, special articles (evaluations, position papers, reviews of nonscientific subjects), membership and legislative news, continuing medical education notices, and programs and policies of the faculty.*

Information for AUTHORS

- ***Letter of transmittal***—The letter of transmittal, which all authors must sign, should include the full names, degrees, titles, and affiliations of all authors, and the name, address, and phone number of the author to whom reprint requests and correspondence should be sent.

  The letter should include a statement to the effect that all authors have participated in the conception and design of the work and in the writing of the manuscript, and that they take public responsibility for it. The authors should attest to the validity and legitimacy of the data, and acknowledge that they have reviewed the final version of the manuscript and approve it for publication.

  In addition, the letter must include a paragraph that transfers copyright ownership to the *MMJ* in the event that the work is published.

- ***Manuscript preparation***—Manuscripts should be submitted to Editor, *MMJ*, 1211 Cathedral Street, Baltimore, MD 21201-5585. Manuscripts must be original material not previously published and not under consideration by another publication. An abstract of 100 to 300 words is required.

  All material, including references, tables, and legends, must be double-spaced. Pages should be numbered. (All abbreviations should be spelled out on first use.) The original manuscript plus one copy should be submitted on standard (8.5" x 11") bond paper. If at all possible, an IBM-compatible disk should be included, with the manuscript entered in a WordPerfect, Multimate, Wordstar, or ASCII format; the transmittal letter should identify the format used.

- ***References***—References are limited to those citations noted in the text. References should be numbered consecutively as they appear in the text and should be kept to a minimum (fewer than thirty-five). Personal communications and unpublished data are not acceptable. At a minimum, references should include names of all authors, complete title of the article cited, name of journal abbreviated according to *Index Medicus* (if abbreviation is not known, journal name should be spelled out fully), year of publication, volume number, and first and last page numbers. Sample references are as follows:

  1. Stevens MB. The clinical spectrum of SLE. Md Med J 1991; 10:875–85.
  2. Ropes MW. Characteristics, manifestations, and pathologic findings. In: Ropes MD, ed. Systemic Lupus Erythematosus. Cambridge, MA: Harvard University Press. 1976; 50–4.

- ***Tables***—Tables should be typed on separate sheets of paper, be numbered, and have a brief descriptive title. Data presented in tables should be self-explanatory and should supplement, not duplicate, the text; the Editor reserves the right to edit tables. Authors should be sure that statistics are consistent in both tables and text.

- ***Illustrations***—Illustrations include material that cannot be set in type. Photographic material must be submitted as high-contrast, glossy prints. Drawings and graphs must be done professionally in india ink on high-grade white drawing paper or be computer generated. Identification—including figure number, the title of manuscript, the name of corresponding author, and arrow indicating top—should be typed on a gummed label and affixed to the back of each illustration. Legends for illustrations should be typed on a separate page with numbers corresponding to those on the photographs or drawings. Recognizable photographs of patients are to be masked and should carry with them written permission for publication. Cost of printing color photographs must be borne by the author.

Checklist

- ☐ Original manuscript and one copy.
- ☐ IBM-compatable disk in WordPerfect, Multimate, Wordstar, or ASCII.
- ☐ Everything double-spaced.
- ☐ Letter of transmittal, signed by all authors, that includes release of copyright, statement of authorship responsibility, title and affiliation of all authors, and identification and phone number of corresponding author.
- ☐ Abstract of 100 to 300 words.
- ☐ Permission-to-borrow letters for any previously published illustrations or tables

- ***Permissions***—Material taken from other sources must be accompanied by written permission from both author(s) and publisher allowing the *MMJ* to reproduce the information/figure.

- ***Editorial responsibility***—All manuscripts are acknowledged upon receipt. They are subject to peer review by an editorial board and, at times, by guest reviewers in appropriate fields of medicine, to determine the originality, validity, and importance of the content and conclusions. Authors are usually notified of the status of their papers (acceptance, revision, or rejection) within 4 to 8 weeks of receipt; however, longer delays are sometimes unavoidable. Reviewers' comments will be returned with rejected manuscripts at the discretion of the Editor. All guest reviewers will remain anonymous.

  Accepted manuscripts become the permanent property of the *MMJ* and are subject to copy editing. (The *Chicago Manual of Style* and the unabridged *Random House Dictionary of the English Language* are used as style guides.) The corresponding author is sent a reprint order form and galley proofs. S(he) then has 48 hours in which to make minor changes and clear all corrections and changes with co-authors; if proofs are not returned by the specified date, they will be considered approved as typeset. ■

The Johns Hopkins Medical Institutions

All courses at the Thomas B. Turner Building unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Medical Education, 720 Rutland Ave., Baltimore, MD 21205 (410-955-2959).

Pediatric allergy and immunology for the practitioner, 14 Cat 1 AMA credits. $255/physicians; $175/residents and allied health professionals. — **May 4–5**

Contemporary issues in the diagnosis and treatment of low back pain — **May 4–6**

In vitro toxicology — **May 8–10**

Rheumatology nursing — **May 12–13**

40th Annual topics in clinical medicine, 39.5 Cat 1 AMA credits, 37 prescribed credits by AAFP. Fee: $750/physicians; $600/residents, fellows, others. — **May 15–19**

Advanced pediatric life support, 20 Cat 1 AMA credits. — **June 12–14**

Design and analysis in clinical trials, 15 Cat 1 AMA credits. — **June 15–16**

21st Annual topics in gastroenterology and liver disease, Cat 1 AMA credits available. Fee: $525/physicians; $275/residents and fellows; postmarked before 9/4/95, $495/physicians; $250/residents and fellows. — **Oct. 11–13**

Continuously throughout the year

Visiting preceptorship in pediatric critical care medicine. Ongoing five-day preceptorship by appointment. 40 Cat 1 AMA/PRA credits. $600.

The department of radiology and radiological sciences offers several courses in abdominal and obstetrical ultrasound. Info: P. Williams, 410-955-3169.

Visiting physicians. Offered throughout the year for experience in the lab and participation in read-in sessions; by appointment only. 40 Cat 1 AMA/PRA credits. $500.

Johns Hopkins medical grand rounds. Accredited audiovisual continuing education series of case discussions for clinicians; 30 topics per year in five bimonthly programs. Individual and group subscriptions. 40 Cat 1 AMA/PRA credits. Info: 410-955-3988.

Johns Hopkins sports medicine grand rounds. Accredited continuing education series of case discussions by a different presenter on the first Thursday of each month. Info: Carol Kelly, 410-383-0600.

University of Maryland

For each course, additional information may be obtained by contacting the Program of Continuing Education, University of Maryland School of Medicine, Room 14-011, BRB, 655 W. Baltimore St., Baltimore, MD 21201 (410-706-3956) or by calling the phone number listed after a specific program. FAX 410-328-3103.

8th Annual trauma anesthesia & critical care symposium, at the Hyatt Regency Hotel, Baltimore, MD. 18.5 Cat 1 AMA credits. Fee: $595. Info: Kimberly Unitas, 410-328-2399. — **May 11–13**

Physician forum HIV: beyond the recommendations—how we really care for AIDS patients, at the Brass Elephant Restaurant, Baltimore, MD. 1 Cat 1 AMA credit. Info: Sylvia Scherr, 410-328-8639. — **May 18**

University of Maryland (continued)

Focus on fever, at the Marriott Inner Harbor Hotel, Batimore, MD. 5 Cat 1 AMA credits. Fee: $75. Info: Jack Blalock, 410-605-7199. — **June 10**

21st Annual family medicine review course, at the Princess Royale Ocean Suite Hotel, Ocean City, MD. 30 Cat 1 AMA/AAFP credits. Fee: $550. Info: Althea Pusateri, 410-706-3956. — **June 25–30**

Managing emergency medical services, at the University of Maryland Baltimore County (UMBC). Sponsored by the UMBC Department of Emergency Health Services and the Maryland Institute for Emergency Medical Services System. Info: Dr. Richard Bissell, 410-455-3776. — **July 2–28**

1995 Advanced pre-operative evaluation and planning for complex deformities, at the Pikesville Hilton Inn, Baltimore, MD. 25 Cat 1 AMA credits. Fee: $450. Info: Steven Kaniecki 410-448-3394. — **Sept. 16–19**

Continuously throughout the year

Optimal dosing in chemotherapy: Adoptive control with carboplatin, video tape, monograph and test. Expires March 1996, 3 Cat 1 AMA credits. Info: 212-924-3044.

Miscellaneous meetings

1995 Risk management program: suit survival/lessons in risk management, sponsored by Medical Mutual Liability Insurance Society of MD. Med Mutual members who attend will receive a 5% discount on 1996 renewal premium. 2 Cat 1 AMA credits. Fee: $40. Info: Toni Davis or Natalie Poole, 410-785-0050, or 1-800-492-0193.

Comfort Inn, Easton	**May 2**
Med Chi Annual Meeting, College Park	**May 5**
Montgomery General, Olney	**May 10**
Medical Mutual, Hunt Valley	**May 11**
Medical Mutual, Hunt Valley	**May 16**
Suburban Hospital, Bethesda	**May 23**
North Arundel Hospital, Glen Burnie	**May 25**
Medical Mutual, Hunt Valley	**June 1**
Harbor Hospital Cntr., Baltimore	**June 6**
P. G. Hospital Cntr., Cheverly	**June 8**
Med Chi, Baltimore	**June 13**
St. Mary's Hospital, Leonardtown	**June 14**
Shady Grove Advent. Hospital, Rockville	**June 15**
Washington Advent. Hospital, Takoma Park	**June 21**
Medical Mutual, Hunt Valley	**June 28**

Miscellaneous meetings (continued)

The Medical and Chirurgical Faculty of Maryland's 1995 annual meeting, at the Inn and Conference Center, College Park, MD. Info: 410-539-0872. **May 4–6**

Clincal auscultation of the heart, sponsored by the American College of Cardiology, at the Georgetown University Medical Center, Washington, DC. 18 Cat 1 AMA credits. Info: 800-257-4739. **May 10–12**

Laparoscopic gastric surgery at the Minimally Invasive Training Institute, sponsored by St. Joseph Medical Center. 6 Cat 1 AMA credits. Info: 410-337-4843. **May 12**

Current concepts in orthopedics, sponsored by the Southern Medical Association and the Southern Orthopedic Association at the Harbor Court Hotel, Baltimore, MD. Cat 1 AMA credits available. Fees: $295-$495. Info: Michelle Williamson, 800-423-4992. **May 19–21**

Lap-assisted vaginal hysterectomy & laparoscopic supracervical hysterectomy at the Minimally Invasive Training Institute, sponsored by St. Joseph Medical Center. 8 Cat 1 AMA credits. Info: 410-337-4843. **May 30 & June 27**

Third international symposium on maritime health, sponsored by the George Washington University Medical Center, at the Maritime Institute of Technology and Graduate Studies, Baltimore, MD. 14 Cat 1 AMA credits. $1350 (includes lodging and some meals). Info: Karen Mayer, 202-994-3921. **June 7–9**

2nd Annual intensive review of internal medicine, sponsored by the George Washington University Medical Center, at the Washington Marriott Hotel, Washington, DC. Info: Deborah Grant, 202-994-4285. **June 7–10**

PHYSICIAN'S RECOGNITION AWARD

During February 1995, the physicians listed below received the American Medical Association (AMA) Physician's Recognition Award. Established in 1968, the award's purpose is to encourage physician participation in continuing medical education and to recognize those physicians who have voluntarily completed programs of continuing medical education.

Hubert J. Alpert, M.D.
Denis L. Bourke, M.D.
Lorin F. Busselberg, M.D.
Robert N. Conrad, M.D.
Paul M. Fine, M.D.
Albert F. Fleury, M.D.
Douglas Frankel, M.D.
Linda K. Franks, M.D.
Mayo F. Friedlis, M.D.
Rene E. Grace, M.D.
Dong Z. Hur, M.D.
Robert A. Ingram, M.D.
Karim Mansouri, M.D.
Louis W. Miller, M.D.
Edmund V. Niklewski, M.D.
Irvin P. Pollack, M.D.
Donald C. Roane, M.D.
Ricardo L. Rodriguez, M.D.
Martin J. Sheridan, M.D.
Paul Snow, M.D.
Charles J. Stahl, M.D.
Farouk A. Sultani, M.D.
Michael P. Vincent, M.D.
Alan R. Weinstock, M.D.
Peter W. Williams, M.D.

Miscellaneous meetings (continued)

3rd Annual board review in family medicine, sponsored by the George Washington University Medical Center, at the Marriott Crystal Gateway Hotel, Arlington, VA. 39 Cat 1 AMA/AAFP credits. Info: Maria Gorrick, 202-994-4285. **June 24–28**

Laparoscopic colon resection at the Minimally Invasive Training Institute, sponsored by St. Joseph Medical Center. 6 Cat 1 AMA credits. Info: 410-337-4843. **June 27**

Diabetic retinopathy: a comprehensive review & update, sponsored by the Retina Institute of Maryland at the Stouffer Harborplace Hotel, Baltimore, MD. 7.5 Cat 1 AMA credits. Fee: $250/physicians, $100/other. Info: 410-337-4500. **Sept. 15**

6th Biannual gastroenterology board review course, sponsored by the George Washington University Medical Center, at the Grand Hyatt, Washington, DC. Fee and credits TBA. **Oct. 7–11**

Medical oncology board review course, sponsored by the George Washington University Medical Center, at the Ritz-Carlton Pentagon City, Arlington, VA. Fee and credits TBA. **Oct. 8–12**

Continuously throughout the year

Fluorescein angiography conference, sponsored by the Retina Center, Saint Joseph Hospital, Baltimore, MD, first and third Mondays of each month; 8:00–9:00 am. Fee: none. Info: R. Classon, 410-337-4500.

PHYSICIAN PLACEMENT SERVICE

The Medical and Chirurgical Faculty of Maryland maintains a Placement Service for the convenience of Maryland physicians, hospitals, and communities in search of candidates for positions available in our state. A detailed description of such opportunities should be forwarded to:

Physician Placement Service
1211 Cathedral Street
Baltimore, MD 21201
410-539-0872
1-800-492-1056

Physicians wishing to locate in Maryland are invited to submit a résumé to be kept on file with the Physician Placement Service. Candidates are requested to inform the Faculty when they are no longer available for consideration opportunities in Maryland.

MMJ announcements for physician placements in the classified advertisements are charged at the regular classified advertising rate

Parris N. Glendening — Governor of Maryland

Martin P. Wasserman, M.D., J.D. — Secretary
Department of Health & Mental Hygiene

J. Mehsen Joseph, Ph.D. — Director
Community Health Surveillance & Laboratories Admin.

Ebenezer Israel, M.D., M.P.H. — Director
Epidemiology & Disease Control Program

DHMH Maryland Department of Health & Mental Hygiene

EPIDEMIOLOGY & DISEASE CONTROL PROGRAM
201 W. Preston Street, Baltimore, Maryland 21201 (410)225-6700

Clearing the Air: Physician Support for Clean Indoor Air

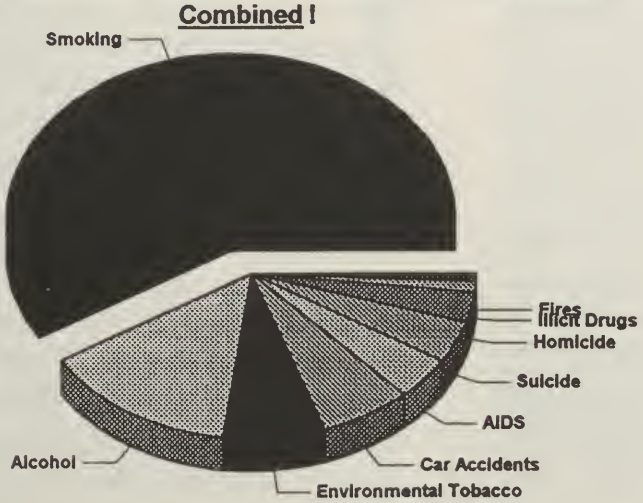
May, 1995

Introduction

The health risks and economic costs of tobacco use are well documented.[1] Continued use of a nicotine delivery system kills over 6,000 Marylanders and costs our economy well over one billion dollars each year.[2] Over the past two decades, evidence has been mounting on the health effects of environmental tobacco smoke (ETS).[3] This evidence prompted the Environmental Protection Agency (EPA) to release a review of the literature on the link between ETS and lung cancer deaths in 1992.[3] Other research showed that ETS is linked to about 35,000 to 40,000 cardiovascular disease deaths each year.[4] As a result, exposure to ETS is a leading cause of death in the United States (Figure 1). In Maryland alone, ETS kills at least 1,000 people annually.[5]

Figure 1

Smoking Kills More Americans Each Year Than Alcohol, Cocaine, Crack, Heroin, Homicide, Suicide, Car Accidents, Fires and AIDS Combined !



Source: Smoke Free Educational Services, Inc., New York, N.Y.

Approximate Number of Deaths	
Smoking	434,000
Alcohol	105,000
ETS	50,000[6]
Car Accidents	49,000
AIDS	31,000
Suicide	31,000
Homicide	22,000
Fires	4,000
Cocaine & Crack	3,300
Heroin & Morphine	2,400

The evidence linking ETS to death and disease inspired many policy and opinion leaders to advocate for protective legislation that would eliminate second-hand smoke from workplaces. Businesses that go smoke free find that a significant number of their workers quit smoking after implementation of the policy.[7] In order to dissuade the legislative movement, the tobacco industry conducted an intensive media campaign to raise doubt about the risks of ETS in the minds of the general public.[8] Their efforts to some degree have been successful. Physicians, because of their role in society, can play a pivotal role in advocating for smoke free workplaces.

Environmental Tobacco Smoke

The National Research Council and the Surgeon General of the United States both did independent reviews of the literature in 1986 to determine the health risks of ETS. Both reports indicated that ETS can cause lung cancer in non-smokers and that children of smokers have a greater number of lower respiratory infections and reduced lung function than children of non-smoking parents.[3]

In 1992, the Environmental Protection Agency issued a report which reviewed the findings of all major epidemiologic studies on ETS. The findings concluded that ETS is a Group A carcinogen causing approximately 3,000 lung cancer deaths per year among adult non-smokers of both sexes. Additionally, ETS significantly impacts the health of children. ETS exposure in children is linked to an increased prevalence of respiratory irritation (cough, sputum, and wheeze), inner ear infection and lower respiratory infections. Though the tobacco industry accused the EPA of using faulty scientific analyses, no credible scientific research or policy organization ever disputed these findings.[3]

Smoke Free Businesses:

Encourage people to stop smoking or smoke fewer cigarettes.

Protect and promote the health and safety of employees thereby reducing legal liability.

Shield themselves from higher health care costs.

May obtain reduced insurance premiums for fire, health, and life insurance policies.

Report lower cleaning and maintenance costs.

Have few problems implementing or enforcing the smoke free policy.

Report increased employee morale and productivity.

Do not lose revenue following the implementation of the smoke free policy.[11]

Will curb Maryland's growing cancer death rate.

Pregnant women in the workforce need protection from ETS. Recent research links ETS exposure with increased pregnancy complications among pregnant women, lower birth weight babies, and increased risk of Sudden Infant Death Syndrome (SIDS).[9, 10]

Exposure to increased concentrations of ETS significantly affects the health status of workers. Food service workers are exposed to approximately 1.6 to 6.1 times higher levels of ETS than office workers. As a result, food service workers suffer from an excess lung cancer risk of at least 50%.[11]

Environmental tobacco smoke is clearly a danger to the health of Marylanders. While over 50% of Maryland workplaces are smoke free, the workplace still is a major source

What You Can Do To Support Clean Indoor Air Policies

1. Show your support for smoke free workplaces. Display posters, no-smoking signs, etc. around your office.
2. Ask your patients to quit smoking. Many local health departments conduct free stop smoking classes.
3. Advise your patients about the dangers of ETS and smoking around children in enclosed environments - especially in vehicles.
4. Write letters-to-the-editor in support of clean indoor air legislation, regulations, and policies.
5. Urge leaders of civic organizations to have smoke free meetings.
6. Offer to speak to community groups on the dangers of ETS.
7. Contact your county Health Officer and offer your support.
8. Call and write your local, state, and federal elected officials in support of clean indoor air.
9. Work with your county medical society to adopt a resolution in support of clean indoor air legislation, regulations, and policies.
10. Testify before the State legislature or your local government's council on the dangers of ETS and why legislative protections are necessary.

of exposure to ETS.[13, 14] Laws or regulations which eliminate ETS from the workplace will protect employees from a known carcinogen, influence employees to quit smoking, and result in improved health for all. Research shows that a legislative or regulatory approach is necessary since small businesses are less likely to be smoke free and often do not implement smoking policies until comprehensive laws or regulations require them to do so.[15] Most Maryland workers already support and favor smoke free workplaces.[13] However public attitudes towards government regulation and legislation are not currently favorable.

Physicians and Clean Indoor Air

The physician is ideally positioned to advocate for the implementation of smoke free policies. Several studies indicate that people value their doctors' advice and will readily act upon it if feasible.[16] It stands to reason that if physicians call for the adoption or support of a smoke free ordinance, for example, many citizens will heed their doctors' advice and support the proposed ordinance.

On Election Day 1994, Talbot County, Maryland residents voted to support an ordinance making workplaces smoke free. The local county medical society, the hospital and several individual physicians actively supported the referendum. Numerous physicians endorsed an open letter to the public which asked residents to approve the referendum. They stated in part, "We urge you to vote yes on Question D so that together, we can become a healthier, more productive county." Local community group leaders received personal phone calls from physicians on the importance of protecting workers from ETS. Doctors wrote supportive letters-to-the-editor of the local newspaper. And many physicians even showed up at he polls to give voters last minute encouragement.

Lack of time is often cited as a reason for not offering patients preventive care. In the case of advocating for sound public health policy, even small commitments of time will make a

larger difference. A phone call or letter to a community leader can often result in an endorsement of smoke free policies. Parents need constant reminding that ETS exposure can hurt a developing child. These reminders can sometimes change parental smoking behavior both at home and while in vehicles.

Summary

Physician involvement in tobacco use prevention is crucial to preventing heart disease and cancer in Maryland. Your efforts to advocate for clean indoor air legislation, regulations, and policies at all levels will influence the public's support of smoke free environments. Even after smoke free legislation or regulations are implemented, physicians have an opportunity to educate the public thereby insuring a smooth transition. Citizens will stop smoking in greater numbers, businesses will benefit, and the public's health will ultimately improve as the workforce goes smoke free.

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Prepared by Glenn E. Schneider, MPH, from the Office of Health Promotion, Education and Tobacco Use Prevention in the Local and Family Health Administration.

We gratefully acknowledge the assistance of Megan Pulliam in the preparation of this manuscript.

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It has been argued that if Medicare covered health promotion/disease prevention services, in addition to acute illnesses, the health of Medicare beneficiaries would improve and the program would save money. **Results of a study to determine if Medicare beneficiaries would use health promotion/disease prevention services indicate that people most at risk for having high-risk symptoms or behaviors (e.g., smoking) may be least likely to use such services.** Study factors associated with greater use of services were the need for relatively little involvement on the part of enrollees (e.g., health care screenings, immunizations), higher level of education, and physician encouragement to use the services. Although the study could not determine whether health promotion services would result in better health and lower morbidity, the authors speculate that at least some people would use Medicare-covered preventive services, especially if instructed to do so by their doctors (*Am J Prev Med* 1995;11:46-53).

According to data obtained from a brief telephone questionnaire developed by the Centers for Disease Control and Prevention, **only about 20% of the population consumes five or more fruit and vegetable servings per day.** Data were obtained from 28,286 people in 16 states, including Maryland (*Am J Public Health* 1995;85:236-239).

Italian researchers report that **a combination of yohimbine and trazodone may be an effective treatment for psychogenic impotence** (*Urology* 1994;44:732-737). Sixty-three patients entered the randomized, double-blind, placebo-controlled, partial crossover study. Data on the 55 patients who completed the trial (8 weeks of placebo, 8 weeks of the active drug combination) indicate that active drug was associated with complete response in 26 patients (47%) and partial response in 14 (25%). Eight patients (6 on active drug, 2 on placebo) dropped out due to side effects (dizziness, gastrointestinal disturbances, and restlessness and agitation). At 3- and 6-month follow-up, response rates were 58% and 57%, respectively.

Of 18 journalists invited to witness a San Quentin execution, more than half later reported (via questionnaire) the presence of dissociative symptoms (e.g., feeling detached from other people). The Stanford authors found that the prevalence of posttraumatic symptoms (e.g., increased emotionalism, decreased concentration, dreams of the execution) was similar to that in people involved in a recent Oakland/Berkeley firestorm. Although there was no evidence of long-lasting distress, the study suggests that **dissociative symptoms may be a common and possibly adaptive response to witnessing violence** (*Am J Psychiatry* 1994;151:1335-1339).

As part of a population-based study of risk factors for cerebral palsy, California researchers compared children (average age, 4.9 years) born with and without CP who weighed less than 1500 g at birth. Multiple data analyses indicate that **in utero exposure to magnesium sulfate may be negatively associated with CP.** The protective relationship persisted across a variety of characteristics of pregnancies and births. Although the authors caution that their study design cannot establish a causal relationship between magnesium sulfate administration and lower CP frequency, their findings warrant a randomized trial (*Pediatrics* 1995;95:263-269).

Cite SEER

Investigations have been completed in six instances involving passengers or flight crew who traveled on commercial aircraft while highly infectious with tuberculosis at the time of the flight (*MMWR Morb Mortal Wkly Rep* 1995;44:137-140). In two cases, *Mycobacterium tuberculosis* was resistant to both isoniazid and rifampin, but organisms isolated from the other cases were susceptible to all antituberculous medications. Investigators concluded that **the risk for *M. tuberculosis* transmission does not appear to be greater on an aircraft than in other confined spaces.** Notification of passengers and flight crew members, which should be conducted by the airline, should be guided by three criteria. First, the person was infectious at the time of the flight. Second, exposure was prolonged (more than eight hours). Third, the first people to be notified should be those who were physically closest to (i.e., in the same cabin with) the infectious person.

Uncontrolled clinical studies have indicated that topically applied local anesthetics are effective in reducing/relieving the postherpetic neuralgia associated with herpes zoster. Recently reported results of a double-blind trial confirm that **topical application of 5% lidocaine gel relieves postherpetic neuralgia by a direct drug action on painful skin** (*Ann Neurol* 1995;37:246-253). In 16 subjects with cranial pain, the gel was applied without occlusion for 8 hours; patients reported pain relief at 30 minutes and at 2, 4, and 8 hours. For limb and torso pain in 23 subjects, gel was applied under occlusion for 24 hours; patients reported significantly lower pain intensity at 8 hours and pain relief and reduced pain intensity at 24 hours. Side effects included mild, transient skin reddening and adhesive abrasions associated with removal of the occlusive covering. There were no adverse systemic effects, and lidocaine blood levels did not exceed 0.6 µg/ml.

Although the adverse interaction between the anticonvulsant carbamazepine (Tegretol) and the macrolide antibiotic erythromycin is thought to be well established, a recent report describes three cases of antibiotic-induced carbamazepine toxicity (*Arch Pediatr Adolesc Med* 1995;149:99-101). All patients (a 3-year-old girl, a 9-year-old boy, and a 17-year-old boy) had been taking carbamazepine for seizure disorders. All developed bacterial infections for which they were prescribed formulations containing erythromycin, and all subsequently presented with signs and symptoms of carbamazepine toxicity. Two of the children required hospitalization. In two cases, the patients had received Pediazole, which contains erythromycin ethylsuccinate, the most commonly cited erythromycin formulation in reports of adverse interactions with carbamazepine. The other patient was prescribed Biaxin, which contains clarithromycin, a methylated form of erythromycin (the authors believe this case to be the first report of clinical toxicity involving clarithromycin in a child on long-term carbamazepine therapy). In addition to the reminder that macrolide antibiotics interfere with carbamazepine metabolism, the authors state: "Care must be taken by prescribing physicians to inquire about concurrent medications and consider their potential interaction. This problem is compounded since these drugs are often prescribed independently by a neurologist (carbamazepine) and a pediatrician (erythromycin)."

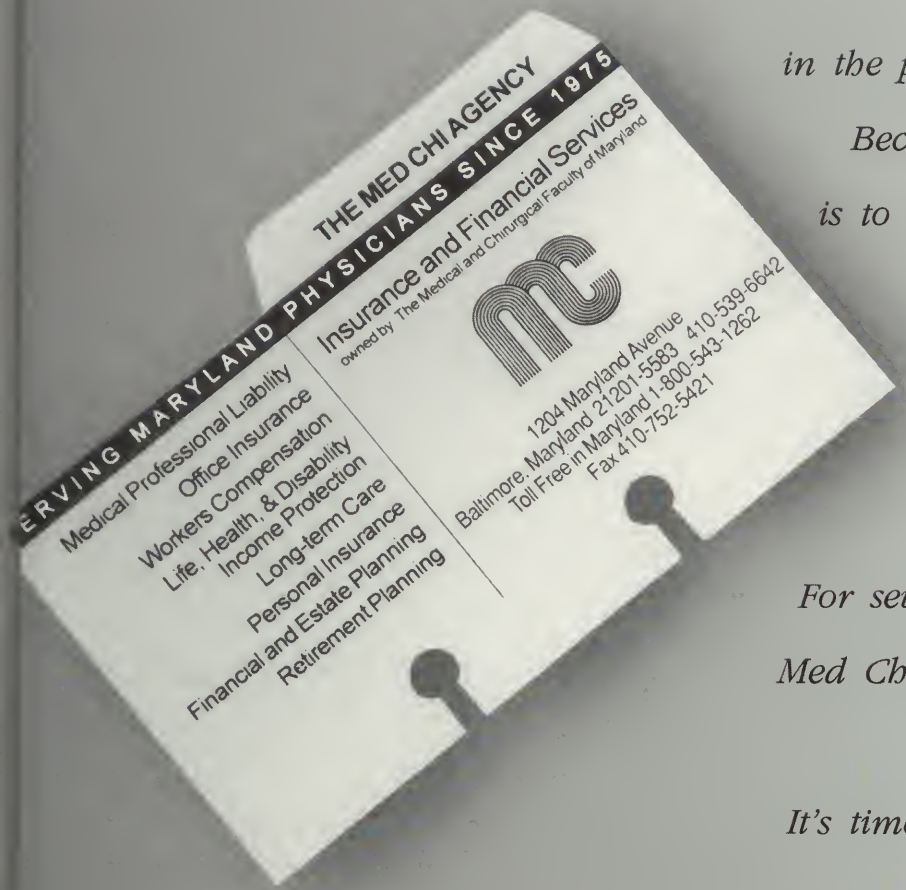
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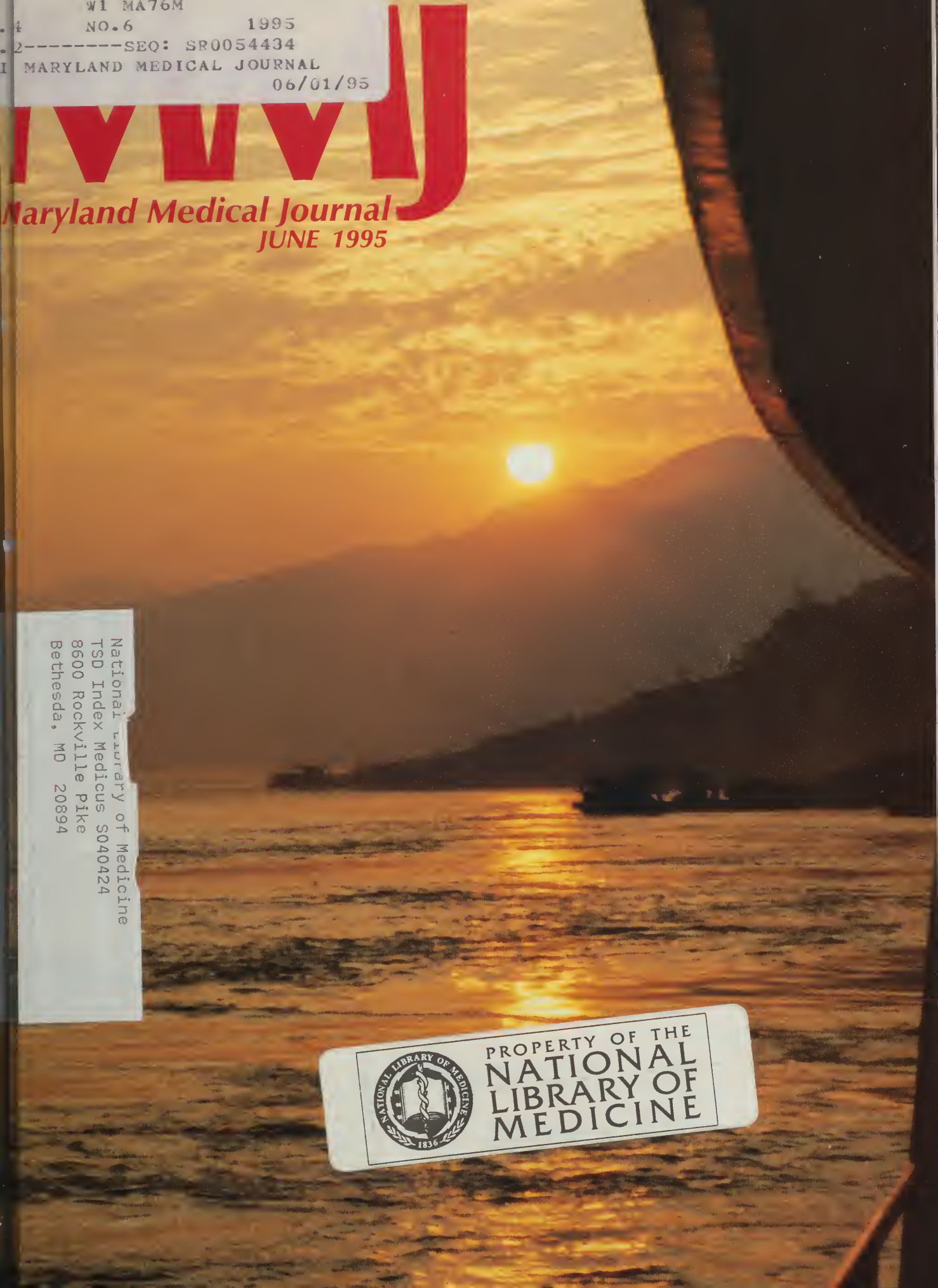
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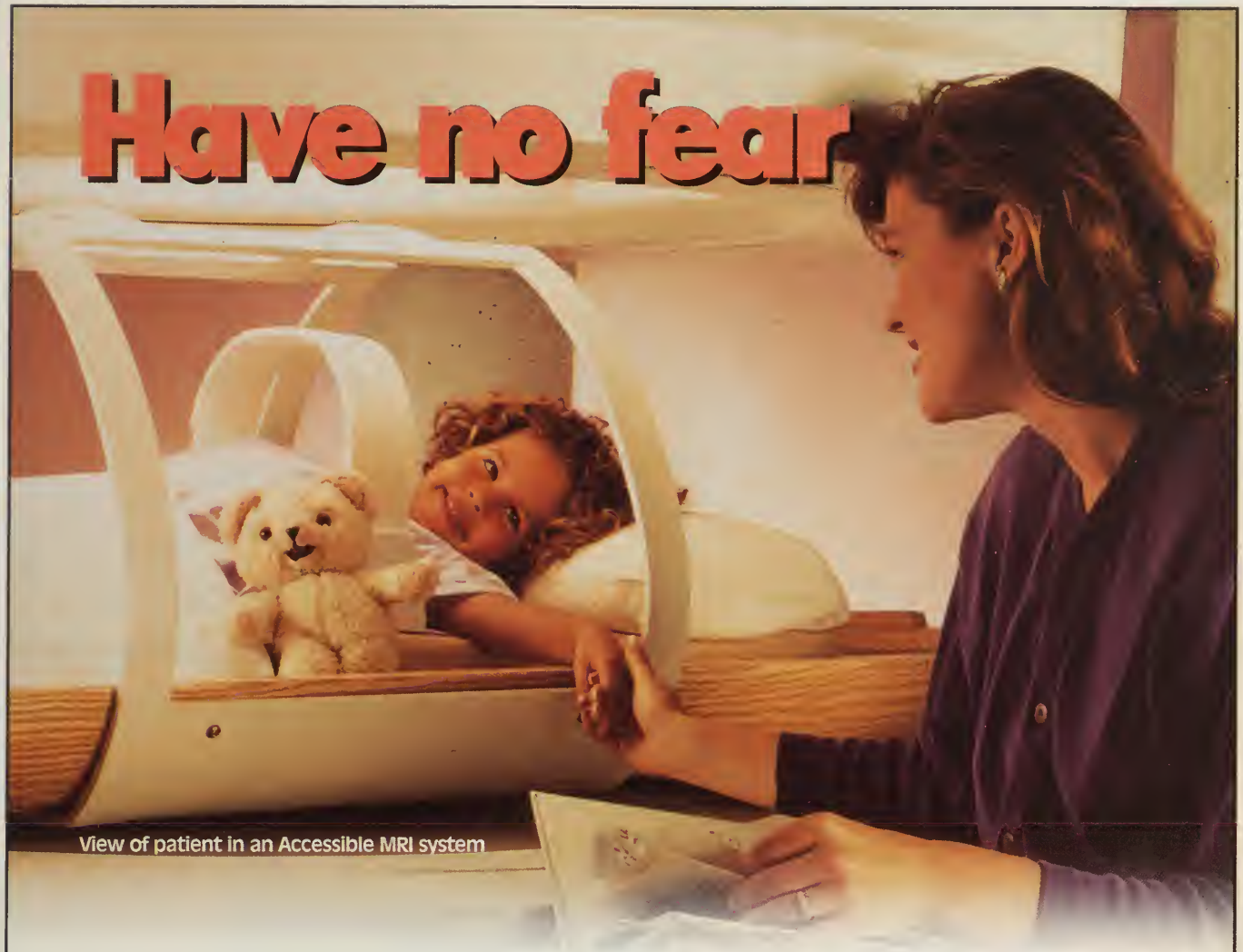
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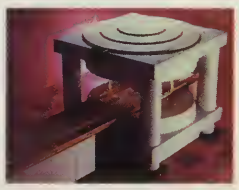
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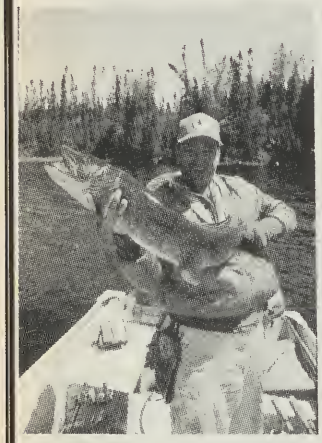
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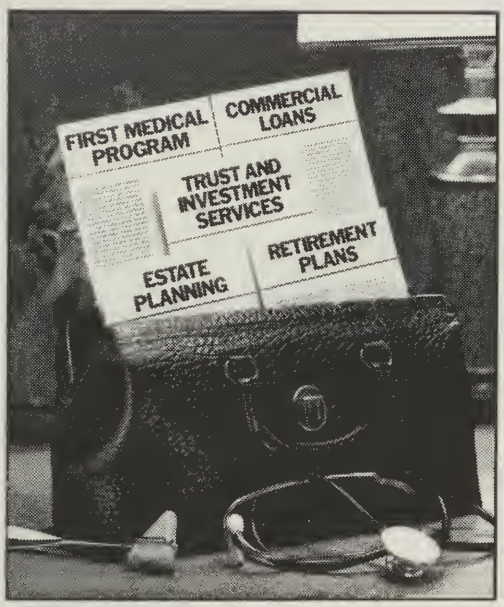
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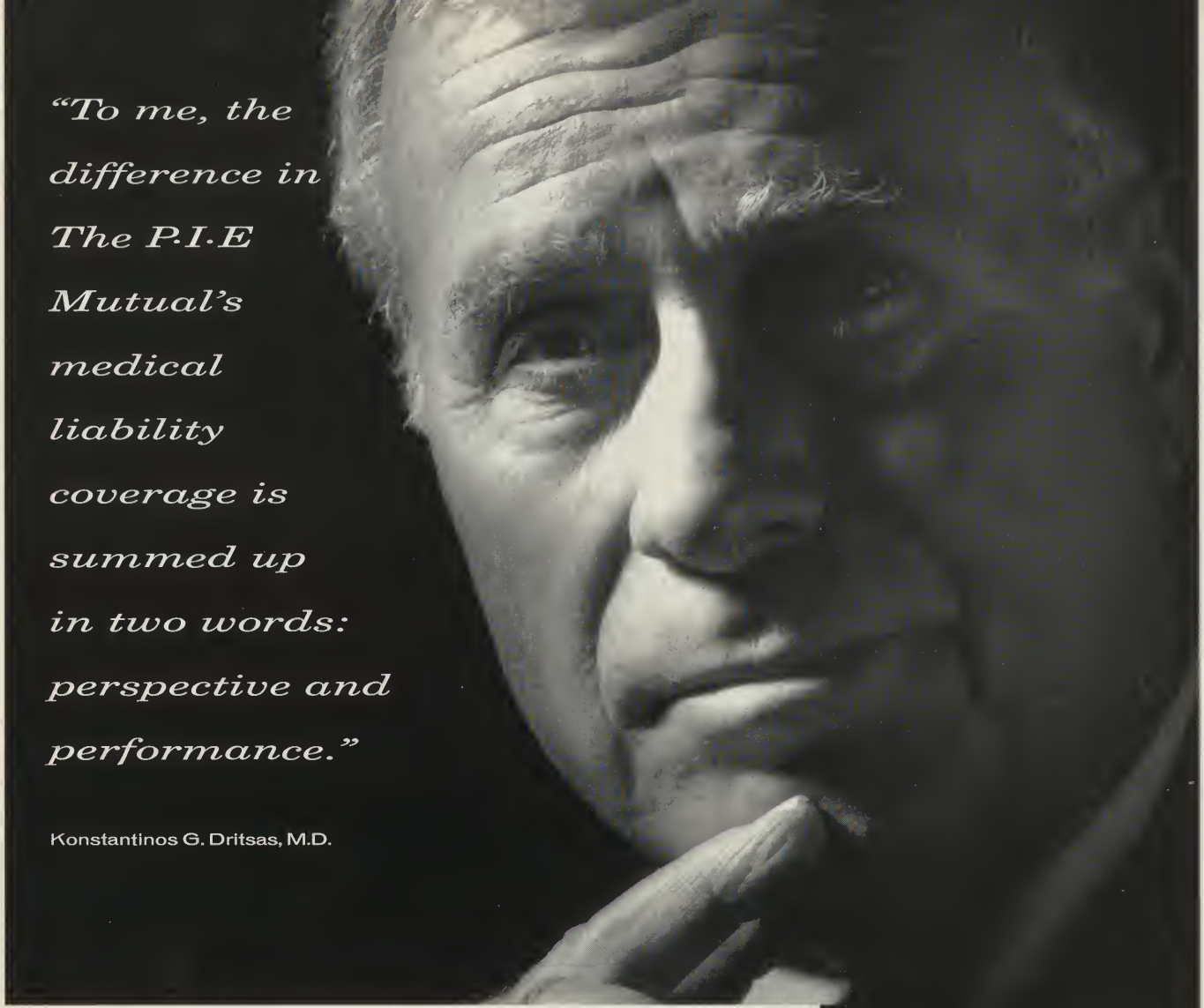
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Med Chi Board of Trustees Elected

On May 6, 1995, the Med Chi House of Delegates elected the following physicians to serve on the Med Chi Board of Trustees. The term is for one year, through the conclusion of the 1996 annual meeting, unless otherwise indicated:

J. Richard Lilly, M.D., President
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Also on the Board of Trustees are:

Donald H. Dembo, M.D., Immediate Past President
George S. Malouf, Sr., M.D., AMA Delegation Representative
Angelo J. Troisi, FACHE, Chief Executive Officer

Also elected by the House of Delegates were the following AMA Delegates and Alternate Delegates (effective 1/1/96–12/31/97):

Alex Azar, M.D., Delegate
George S. Malouf, Sr., M.D., Delegate
Henry N. Wagner, M.D., Delegate
Allan D. Jensen, M.D., Delegate
Louis C. Breschi, M.D., Alternate Delegate
Reynaldo L. Lee-Llacer, M.D., Alternate Delegate
Shannon Pryor, M.D., Alternate Delegate (Resident)
Mary Guye, Alternate Delegate (Student)

Others currently serving:

J. David Nagel, M.D., Delegate
Joseph Snyder, M.D., Delegate
Roland Smoot, M.D., Delegate
Jose M. Yosuico, M.D., Alternate Delegate
Donald H. Dembo, M.D., Alternate Delegate

Awards Presented and Announced During the 1995 Annual Meeting

Wyeth-Ayerst Physician Award for Community Service
Howard M. Silby, M.D., Montgomery County

Certificate of Recognition for Outstanding Committee Chairpersons
Robert J. Ancona, M.D., Immunizations and Infectious Diseases Subcommittee
Joseph Berkow, M.D., Managed Care and Third Party Liaison Committee
Howard L. Siegel, M.D., Legislative Committee

Martin P. Wasserman, M.D., J.D., Council on Scientific Affairs

Henry and Page Laughlin Award for Citizenship
Martin P. Wasserman, M.D., J.D., Secretary, Department of Health and Mental Hygiene

Henry N. Wagner, Jr., M.D. Science Award
Jeremy D. Collins from Derwood, Maryland

George S. Malouf, Sr., M.D. Community Service Award
Jamal Weems from Baltimore, Maryland

15th Annual Med Chi Photo Contest
First Place - John B. DeHoff, M.D.
Second Place - Chris Papadopoulos, M.D.

Award for Excellence in Organized Medicine
Jeffrey W. Bitterman, MC, USNR, Uniformed Services University of the Health Sciences
Kelly Gebo, Johns Hopkins University School of Medicine
Lisa Smith, University of Maryland School of Medicine

1995 Med Chi Semiannual Meeting

The 1995 Med Chi Semiannual Meeting will be held Friday, September 8, through Sunday, September 10, at the Princess Royale Oceanfront Hotel and Conference Center, Oceanfront at 91st Street, Ocean City, Maryland.

Med Chi has reserved a block of rooms at the following group rates: $126 per night for a single/double occupancy oceanview suite and $169 per night for a single/double occupancy oceanfront suite (tax and incidentals not included). Two- and three-bedroom condos are also available. To reserve a room, call the Princess at 410-524-7777 or 1-800-4ROYALE (1-800-476-9253), and tell them you will be attending the Med Chi meeting. Please reserve early — **reservation deadline is August 8, 1995,** but rooms may fill prior to this date.

Medicare HMOs

The Philadelphia Regional Office of the Health Care Financing Administration (HCFA) has provided the following information:

> "During the past several years, HCFA has seen the number of Medicare HMOs double in the Mid-Atlantic Region, from 13 to 26. We have also seen an explosion in the number of Medicare HMOs that charge no monthly premium to provide services. The $0 monthly premium applies only to the premium charged by the HMO; you still must pay the monthly premium for Medicare Part B. Medicare beneficiaries may attempt to cancel their Medicare Part B because they think that the $0 premium also applies to the Medicare Part B premium. **This information is incorrect!** Medicare beneficiaries enrolling in Medicare HMOs **must** continue paying their Medicare Part B premium, even for those HMOs who charge no monthly premium to provide services."

Mammography Screening

HCFA will be conducting a nationwide campaign beginning in May designed to increase the awareness of women aged 65 and over about the importance of mammography screening. Breast cancer is the second leading cause of death among women and the incidence of breast cancer occurs most frequently in women 65 and over. HCFA's campaign will stress early detection through mammogram screening every two years. Medicare payment will be made for screening every two years for women 65 and older. Women who have been diagnosed with breast cancer or show signs of breast cancer are eligible for more frequent diagnostic mammograms; also, Medicare will help to pay for mammography screening for certain at risk women between ages 35-65 who receive Social Security disability benefits.

Patient Referrals to Green Spring Mental Health

According to Blue Cross Blue Shield of Maryland (BCBSM), when patients request a non-emergency appointment to Green Spring Mental Health, they are normally scheduled to see a psychologist or social worker for their initial appointment. If, as the primary care physician, you are familiar with the patient's psychiatric problems and have reason to believe that the patient is likely to need medication, you may suggest that the patient be seen by a psychiatrist and Green Spring should be called to request a psychiatric appointment on the patient's behalf. The telephone numbers for Green Spring are: 800-245-7013 or 410-992-6640.

Tennessee Court of Appeals Rules Against TMA

The Tennessee Court of Appeals ruled on April 20, 1995 that the Tennessee Medical Association (TMA) lacked standing to sue TennCare which is the state's program of health care for the needy. According to TMA, the Court of Appeals decided that "both the TMA and its member physicians lacked standing to bring any suit concerning TennCare because, in the Court's opinion, the case record (depositions, etc.) reflected 'that TennCare recipients have received abundant and appropriate medical services.'" The Court found that TennCare provided recipients with more medical care and emphasized primary care. The Court also found that TMA had not demonstrated any injury to its members and patients that could be traced to TennCare activities.

The TMA filed evidence showing how much harm physicians were suffering and how difficult it was (and is) for patients to find care. TMA is looking at the possibility of appealing to the Supreme Court.

Help Your Patients Stop Smoking

During the recently held Med Chi annual meeting, Martin P. Wasserman, M.D., J.D., Secretary, Department of Health and Mental Hygiene, made presentations on several public health issues. One presentation he participated in included information on how physicians can help their patients stop smoking. A manual entitled "How to Help Your Patients Stop Smoking," was distributed during the presentation. Published by the National Institutes of Health and written by the National Cancer Institute, this very helpful 80-page publication can be obtained without cost by calling 1-800-4-CANCER (or 1-800-422-6237). No doctor's office should be without it!

Herpes Support Group

Baltimore Help is a confidential support group for individuals concerned with genital herpes. The group meets on the second Thursday evening of each month. For information on meetings in the Baltimore/Washington area, call 410-792-8788 (24-hour line).

Radiology Time Capsule

To celebrate radiology's 100th anniversary, a time capsule is being constructed by 3M Medical Imaging Systems and Radiology Centennial, Inc. (RCI). Content ideas, which should portray the state of radiology in 1995 and its first 100 years, will be accepted through July 31, 1995. For more information and submission guidelines, contact Bill Fuesz, at 612-733-8329, or write to: RCI/3M Radiology Centennial Time Capsule, 3M Center, Building 223-2SW-03, St. Paul, MN 55144-1000.

Thanks to Our Exhibitors and Sponsors

Med Chi would like to thank the following companies for exhibiting, or participating in the exhibit sweepstakes, at the 1995 Med Chi Annual Meeting:

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In addition, Med Chi would like to extend a special thanks to the following sponsors for support of the 1995 Med Chi Annual Meeting:

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LETTERS TO THE EDITOR

Paying for health care: there is no utopia—or free lunch

In a recent letter to the editor (*Md Med J* 1994;43:954-955), Wayne C. Spiggle, M.D., strongly advocated that we seriously consider a single payer system. In reply, Donald T. Lewers, M.D., questioned the merits of such a system (*Md Med J* 1995;44:195-196). It is my belief that none of the changes thus far proposed, or likely to be proposed, will ever be considered ideal. Yet we are faced with an existing health care system that threatens to bankrupt us. Change is therefore inevitable.

The only question can be, what changes will allow us to maintain a quality product in the most efficient manner that will best satisfy both those who must receive it and those who must provide it? To answer that question in a reasonable manner devoid of emotion, we must examine the excesses generated by physicians, other health care providers, lawyers, patients, government, and others intimately involved.

We would be naive to fail to admit that some blame lies with physicians who overuse the system. Some overuse is due to unrealistic demands of patients who insist on studies and therapies which their complaints do not justify. In other cases, overuse is due to defensive medicine practiced to avoid the possible threat of lawsuits. A sizable portion, however, is due to physician avarice. In any case, physician overuse must not be allowed to continue.

We need to develop practice guidelines for most problems. Physicians who adhere to these measures must be immune from malpractice allegations. Those who elect to stray from accepted guidelines should be permitted to do so provided they can justify their actions. The excessive use of procedures also should be controlled by adjusting fees to reflect accurately the length of time and degree of training required to perform them.

The legal profession's current lottery approach toward alleged malpractice must be curbed. It is inconsistent to believe that in the United States, where it is generally acknowledged that the finest and most sophisticated medical care is rendered, we should also be plagued with the greatest amount of litigation. We need to study the controls placed on this practice by other nations and adopt appropriate limitations.

The largest number of medical care dollars—roughly 25% of all expenditures—is diverted to the insurance carriers and managed care facilities, whose retention of vast amounts for advertising, excessive paperwork, and ever-increasing profits is scandalous. In most of these companies, everything revolves around the bottom line. It is no accident that they are buying each other out for billions of dollars. It is easy to understand how grossly unfair the situation is when one considers the salaries and benefits received by the managers of these "medical" corporations—all essentially controlled by nonmedical personnel.

Last summer, *The Sun* (July 24, 1994) listed Maryland businesses that pay chief executive officers the highest compensation in the forms of salaries, bonuses, stock options, etc. Two managed care companies were listed in the top six. The third highest was Mid Atlantic Services, Inc., with headquarters in Rockville, which paid its CEO $3,706,771 in total compensation for



1993. Integrated Health Services, Inc., headquartered in Owings Mills, paid its CEO $3,185,851 in total compensation for the same year. *The Sun* also noted that he has accumulated an "estimated present value of options granted" to the tune of $16,400,000. There were undoubtedly additional millions scattered among other executives. These wasted resources could be used more appropriately to provide care for those presently uninsured, to make more equitable payments to those who render the services, and to diminish costs to patients.

Finally, patients must be educated to the fact that, even in the present era, there are many medical problems that we cannot yet adequately treat. They need to understand that their longevity and well-being depend largely on factors they can control, such as abstaining from the use of tobacco and drugs, eating a proper diet, avoiding obesity and unnecessary stress, and getting adequate exercise and rest. Preventive medicine must be emphasized.

In my opinion, the most effective manner in which the above can be accomplished would be a single payer system. I am not suggesting a utopia, but simply the more acceptable of less-than-perfect choices. I have no illusions as to the federal bureaucracy's efficiency in the administration of funds. The level of federal government involvement needs to be limited to the collection and distribution of funds to the states or local subdivisions on a predetermined, fixed formula including population, cost of living in the area, previous statistics on morbidity, etc. Local groups should then be responsible for how the fixed number of dollars can be used most efficiently. The percentage of total funds available for administrative activity needs to be limited by law.

Because we already spend approximately 14% of our gross national product for medical care, I would also suggest the same percentage initially be considered the cap on these expenditures. Only with that limitation before us will everyone face the issue of eliminating waste and unnecessary spending. Should the people wish more, they could then have the right to receive additional services by adopting a system of small partial payments or agree to increase total funds for medical care (increased taxes).

The days of the free lunch are behind us.

MARION FRIEDMAN, M.D.
Baltimore, Maryland ■

Letters To The Editor

The editorial board of the *Maryland Medical Journal* welcomes comments, criticisms, recommendations, and observations from all its readers. Please submit letters to

Editor
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Pankaj Pasricha, M.D., assistant professor of medicine at The Johns Hopkins University School of Medicine, is the lead author of a study indicating that botulinum toxin may be effective in relieving contraction of the esophageal sphincter in patients with achalasia. Results of the study were published in the *New England Journal of Medicine* (1995;332: 774–778).

Michael Miller, M.D., of the division of cardiology at the University of Maryland Medical System, is the lead author of a study that found coronary risk factors in patients admitted for coronary artery bypass grafting may be under-reported by admitting house officers. Other UMMS physicians involved in the study were **Karen Konkel, M.D., David Fitzpatrick, M.D.,** and **Robert A. Vogel, M.D.** Study results were published in *The American Journal of Cardiology* (1995;75:736–737).

Sharon Fekrut, M.D., Eugene de Juan, Jr., M.D., and **Peter A. Campochiaro, M.D.,** of the Wilmer Eye Institute are authors of a report indicating oral 13-cis-retinoic acid may decrease proliferative vitreoretinopathy and increase the rate of retinal attachment after surgical repair. Results of the study were published in *Ophthalmology* (1995;102:412–418).

Richard H. Roettger, M.D., of the Uniformed Services University of the Health Sciences in Bethesda, is among the authors of a report on penetrating thoracic injury in children due to ball bearing (BB) shot. The report was published in *The Journal of Trauma* (1995;38: 384–389).

Roland R. Lee, M.D., of the department of radiology at The Johns Hopkins University School of Medicine, is co-author of a study that found proton MR spectroscopy is more sensitive than conventional MR imaging in detecting central nervous system involvement in AIDS dementia complex. The report was published in *Radiology* (1995;195:58–64).

Steven J. Kittner, M.D., associate professor of neurology at the University of Maryland Medical Center, is the principal investigator of a study involving medical records of more than 1 million women in central Maryland and Washington, DC, that showed pregnancy and the postpartum period are associated with a small excess risk of stroke. Study results were presented in February at the American Heart Association 20th International Joint Conference on Stroke and Cerebral Circulation, held in Charleston, South Carolina.

William W. Scott, Jr., M.D., of the departments of radiology and radiological sciences at The Johns Hopkins Medical Institutions, is the lead author of a study designed to compare accuracy of interpretation by radiologists and emergency medicine physicians of conventional radiographs and digitized images on an electronic workstation. Results of the study were published in *Radiology* (1995;195: 223–229).

William T. Carpenter, Jr., M.D., and **Carol A. Tamminga, M.D.,** of the Maryland Psychiatric Research Center in Baltimore, are among several experts invited to comment on a lead article in the *Archives of General Psychiatry* (1995;52: 173–188) reviewing the risks and benefits of neuroleptic withdrawal in patients with schizophrenia.

Neil Graham, M.D., associate professor of epidemiology at The Johns Hopkins University School of Hygiene and Public Health, is the principal investigator of a study indicating that predictors of AIDS-free time and survival in HIV-positive men receiving zidovudine may include increased CD4 count, decreased levels of neopterin, and no increase in the number of symptoms. Study results were published in *Clinical Infectious Diseases* (1995;20:352–362).

Howard Weiss, M.D., is a contributing author of the fifth edition of *The Manual of Neurologic Therapeutics,* published in 1994 by Little, Brown & Co. Dr. Weiss is an attending neurologist at Sinai Hospital of Baltimore.

Eli Y. Adashi, M.D., is the co-author of a report published in *Fertility and Sterility* (1995;63: 439–463) indicating that laparoscopic induction of ovulation may be useful in some patients with polycystic ovary syndrome who remain anovulatory despite clomiphene citrate therapy. Dr. Adashi is a professor of obstetrics/gynecology and physiology and the director of reproductive endocrinology at the University of Maryland Medical Center.

David G. Hunter, M.D., and **David L. Guyton, M.D.,** of the Wilmer Eye Institute report that in patients who have cataract surgery, inferior oblique muscle injury may be due to local anesthetic myotoxicity (*Ophthalmology* 1995;102:501–509).

Charles E. Wiles, III, M.D., director of the multiple trauma intensive care unit at the R Adams Cowley Shock Trauma Center in Baltimore, is a member of the Violence Prevention Task Force of the Eastern Association for the Surgery of Trauma, which reported on the role of firearms in violence in America (*J Trauma* 1995;38:163–168).

Barbara White, M.D., of the University of Maryland School of Medicine and the VA Medical Center in Baltimore, is the lead author of a report on guidelines for scleroderma clinical trials developed by the American College of Rheumatology Committee on Design and Outcomes in Clinical Trials in Systemic Sclerosis (Scleroderma). **Marc C. Hochberg, M.D., M.P.H.,** also of the University of Maryland School of Medicine, is among the co-authors (*Arthritis Rheum* 1995;38:351–360).

Eric J. Kraut, M.D., of the Uniformed Services University of the Health Sciences in Bethesda, is co-author of a case report describing the role of ultrasound in detecting blunt rupture of the infrarenal inferior vena cava. The report was published in *The Journal of Trauma* (1995; 38:402–405).

Henry J. Silverman, M.D., is the lead author of a prospective study of the extent to which patients discuss and prepare advance directives after being exposed to a program designed to implement the Patient Self-Determination Act (*Arch Intern Med* 1995;155: 502–510). Dr. Silverman is director of the medical intensive care unit at University of Maryland Medical Center and associate professor of medicine at the University of Maryland School of Medicine.

Daniel J. Safer, M.D., of the Baltimore County Health Department, and **John M. Krager, M.D., M.P.H.,** of The Johns Hopkins University School of Medicine, are authors of a report indicating that more elementary school students who take stimulant medication for hyperactivity/inattention are continuing to take the medication into their teens (*Pediatrics* 1994;94:462–464).

Five Maryland physicians are contributors to the thirteenth edition of *Harrison's Principles of Internal Medicine* (New York, McGraw-Hill, 1994). They are **Daniel B. Drahman, M.D.,** professor of neurology and neurosciences and director of the neuromuscular unit at The Johns Hopkins University School of Medicine; **Randall K. Holmes, M.D., Ph.D.,** chairperson of the department of microbiology and immunology at the Uniformed Services University of the Health Sciences in Bethesda; **Matthew Pollack, M.D.,** professor of medicine at the Uniformed Services University of the Health Sciences; **David Valle, M.D.,** professor of pediatrics and molecular biology and genetics at The Johns Hopkins University School of Medicine; and **Theodore E. Woodward, M.D., M.A.C.P.,** professor of medicine emeritus at the University of Maryland School of Medicine.

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  Washingtonian, April 1995
- "STDs: What You Don't Know Can Hurt You"
  MS., May 1995
- "Out of Africa: Major Medical Discoveries"
  Saturday Evening Post, April 1995
- "Lasers: Bright Lights of the Medical World"
  Cosmopolitan, May 1995
- "The New Diet Pills"
  Reader's Digest, May 1995
- "More Facts About the Fat Gene"
  Self, May 1995
- "Allergy Season Got You Down?"
  Shape, May 1995
- "New Treatment for Premature Ejaculation"
  Muscular, June 1995
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- "Breast Cancer: 5 Lifesaving Secrets"
  McCall's, May 1995
- "Life & Death Dilemmas in the High-Tech Nursery"
  Technology Review, April 1995
- "Body Shock. Diary of a First Pregnancy"
  Glamour, May 1995
- "Sick and Tired. Causes and Cures for Fatigue"
  Allure, May 1995
- "Skin Cancer: Would You Know It If You Had It?"
  Ladies Home Journal, May 1995
- "26 Home Remedies for Colic"
  Parents, May 1995
- "Is Your Heart Really Healthy?"
  Muscle & Fitness, June 1995
- "15 Ways to Speed Up Weight Loss"
  Redbook, May 1995
- "Breast Cancer. What To Do To Protect Yourself Now"
  Good Housekeeping, May 1995
- "Should You Still Worry About Cholesterol?"
  Vogue, May 1995
- "Good News for Bad Backs"
  Reader's Digest, May 1995
- "When Less Is More (My Breast Reduction Surgery)"
  Cosmopolitan, May 1995
- "Gesundheit!"
  Genre, April
- "The Brain That Misplaced Its Body"
  Discover, May 1995

A brief history of the first 33 years of the Addictions Committee

Aware of the prevalence of untreated alcoholism, the Baltimore Area Council on Alcoholism requested assistance from the executive administration of the Medical and Chirurgical Faculty of Maryland. As a result, the Subcommittee on Alcoholism, which reported to the Committee on Post Graduate Education, Preventive Medicine and Public Health, was established in 1962.

The designated subcommittee chairperson, John H. Hirschfeld, M.D., promptly organized a cohesive and diversified membership that held its initial meeting December 18, 1962. The fledgling unit included Frank L. Iber, M.D., from The Johns Hopkins University School of Medicine; Abraham M. Schneidmuhl, M.D., founder of Baltimore City's Health Department Outpatient Alcohol Clinics; Isadore Kaplan, M.D., medical director of the B & O Railroad; and Irene Hitchman, M.D., superintendent of Springfield State Hospital. Med Chi's recording secretary for that meeting was Ms. Bernadette Lane, who currently is the executive director of the Baltimore City Medical Society. As noted in the *Maryland Medical Journal* (July 1963), "The Subcommittee on Alcoholism recommends that the Medical and Chirurgical Faculty go on record as favoring increased emphasis on the treatment of alcoholism in post graduate education programs, in general hospitals and that all general hospitals be encouraged to accept alcoholic patients."

Led by Dr. Schneidmuhl, committee members began canvassing city and county physicians and hospitals, educating them in the recognition and treatment of alcoholism. More than 400 copies of the American Medical Association's *Manual on Alcoholism* were distributed to local and state physicians.

The subcommittee also became involved in what was then a polemic medical-legal controversy regarding the nature of alcoholism. The subcommittee supported a mandate that alcoholism be classified as a medical illness and not as an immoral, criminal offense with routine penal incarcerations. The Annotated Criminal Code of Maryland had read in part, "being found drunk or acting in a disorderly manner to the disturbance of the public peace is a misdemeanor punishable by a $50.00 fine or 60 days in jail or both." In 1959, however, the Maryland General Assembly had ruled that "alcoholism is hereby recognized as an illness and public health problem." Police were instructed to escort nonviolent drunks who required detoxification to hospital emergency rooms, detoxification centers (treatment houses), or other appropriate facilities. Implementation of the statute unfortunately was initially ineffective because there were no quarterway or halfway houses in existence and general hospitals, with the exception of Church Home and Hospital, had no trained staff to treat acute alcoholics.

Med Chi changed the subcommittee to full committee status in 1978. By 1982, committee membership had peaked to include 23 physicians and 11 advisory members. The group was blessed with experts such as Drs. Conrad Acton (Baltimore City jail physician), Torrey Brown, Lewis Gundry, Harry F. Klinefelter, Irving and son Bruce T. Taylor, Maxwell N. Weisman, and Charles L. Whitfield. Nonphysician consultants included W.T. Gibbs and Reverend Harry Shelley, among others. In 1986, associated with the increase in drug abuse, the committee's title was altered to the Committee on Alcohol and Chemical Dependency. Led by chairperson Franklin T. Evans, M.D. (1989 to 1993), an anti-tobacco campaign was instituted to help reduce the medical consequences of tobacco use.

As the work of the committee expanded over the years to include alcoholism, drug addictions, and the diseases caused by tobacco use, in 1993, the committee requested that its name be changed to the Addictions Committee. The new name was approved by Council in June 1994.

The current committee is fortunate to have a number of new members, as well as those with years to decades of committee service. Advisory members include Ludwig Lankford, director of the Office of Education and Training for Addictions Services, State of Maryland Alcohol and Drug Abuse Administration; Phil McKenna, coordinator of the Employee Medical Assistance Program, Baltimore Gas and Electric Company; and W. Robert

Miller of the American Council on Alcoholism. They have held extensive membership on the committee, with 22, 15, and 14 years of continuous servitude, respectively.

ISADORE KAPLAN, M.D.
JOHN H. HIRSCHFELD, M.D.
Dr. Kaplan is one of the founding members of the Addictions Committee. The late Dr. Hirschfield also was a founding member.

Acknowledgement

Many thanks to Ms. Margaret Burri, Med Chi Library Administrator/Archivist, for her kind assistance. ■

The Addictions Committee today

As we reviewed the history of our committee, we were struck by the fact that history is again threatening to repeat itself regarding treatment of the addictive diseases. Again and again we hear the press, legislators, and talk show hosts characterize those with the serious primary diseases of alcoholism/drug addiction as *abusers*. The way in which the word is used often seems to imply that people with these diseases not only intentionally abuse their own bodies, but society as well. Once again, funding for facilities for detoxification and for more definitive treatment has been progressively decreased.

As gloomy as the current outlook appears, the state of affairs is considerably improved compared to the time the committee was formed. Thanks to the outstanding recent work of Med Chi investigators (see the article by Duszynski, Nieto, and Valente), we know that many more physicians today recognize that alcoholism and drug addiction are primary treatable diseases. Nevertheless, most of this group of physicians did not routinely screen for these diseases and 24% said they never encountered drug- or alcohol-affected patients in their practice.

Because of these facts and our belief that the overwhelming medical, personal, and societal tragedies caused by alcoholism and other drug addictions will materially be reduced only with a concerted effort by all of us who practice medicine, we requested permission to prepare this issue of the *Maryland Medical Journal*. In it we have examined and presented evidence that treatment works. There is an updated review of the state of physician attitudes and knowledge about these disorders, as well as a review of current educational programs in Maryland. Two articles describe the role of the primary physician in initiating treatment; another examines the often decisive roles of the family along with the physician.

As with many chronic diseases, it can be difficult to obtain strong statistical data proving that alcoholism treatment works. Such data, however, are now available. On page 435, we present a summary of one set of these data showing that preemptive treatment of alcoholism substantially reduces subsequent health care costs for addicts and members of their families. We present the summary in a "tear sheet" form in the hope that you will help us disseminate these data. The article by Silbersiepe and Hardy presents more evidence of health benefits enjoyed by alcoholics after treatment.

Finally, we have tried to address a common problem for physicians in practice: how, in a busy practice setting, do we diagnose and begin to intervene in these diseases? On page 437, you will find another tear sheet that summarizes some easy, quick diagnostic tools.

We hope that you may find the material presented in this special issue of the *Maryland Medical Journal* relevant to your practice.

PATRICIA A. MCINTYRE, M.D.
CATHERINE E. STARK, CCDC
ISADORE KAPLAN, M.D.
Dr. McIntyre is chairperson of the Addictions Committee, Ms. Stark is a physician rehabilitation advocate for the Physician Rehabilitation Committee, and Dr. Kaplan is one of the founding members of the Addictions Committee. ■

Obituaries

Members of the Addictions Committee were saddened by the deaths of two of our founding members, Dr. Schneidmuhl and Dr. Hirschfeld, and a third early member, Dr. Acton, during the 1994-1995 term of the committee. Obituaries of these pioneers in the field of alcoholism, prepared by Dr. Isadore Kaplan, are included in this issue of the *Maryland Medical Journal,* which is dedicated to their memory.

CONRAD BERENS ACTON, M.D.

A board-certified internist, a family practitioner, and an assistant physician with the Baltimore City Health Department, Dr. Acton died of pneumonia July 12, 1994, at Union Memorial Hospital in Baltimore. He was 91.

Born in Salem, New Jersey, Dr. Acton graduated Haverford College in 1925 and received his medical degree in 1929 from The Johns Hopkins University School of Medicine. His training continued with a two-year internship at Baltimore City's Chronic Hospital (now Bayview Medical Center) and another two years as a pathology resident at Johns Hopkins Hospital. From 1933 until his retirement in 1989, he had offices in his East Baltimore home, not distant from Hopkins Hospital. In addition, he worked as a post mortem physician and pathologist at Baltimore City's Bayview Hospital.

Early in his career, Dr. Acton taught medical students from both Hopkins and the University of Maryland in the art and science of physical diagnosis. As a fledgling sophomore in 1934, I was awed by his knowledge of the cardiovascular system as it related to normal and abnormal physical findings.

A reservist during World War II, Dr. Acton was sent to the Tripler Army Hospital in Honolulu, Hawaii, in 1942, where he functioned as a medical administrator and treating physician. While stationed there, he met and married a Red Cross volunteer worker, Katherine E. Howard. He returned home to re-open his medical office in 1945, but retained military status until he retired from active service in 1963 as a full colonel in the 457th Reserve Hospital.

From 1960 to 1968, Dr. Acton served as a part-time physician at the Baltimore City Jail, and from 1978 to 1989, he was a medical consultant in Baltimore City's Social Services Department. He was a genuine workaholic, vested in numerous and varied medical activities. Not only did he have a large office practice, with house calls, he also taught at the two local medical schools. He frequently volunteered his services in medical organizations, holding active membership in the Baltimore City Medical Society, the American Medical Association, and the Medical and Chirurgical Faculty of Maryland. At Med Chi, he was a member of the Medical-Legal Committee from 1955 to 1970, becoming its chairman in 1970; the Committee on Alcoholism from 1982 to 1987; and the Library and History Committee from 1984 to 1992.

"Con," as he was fondly known by his peers and fellow committee members, was a throwback to Norman Rockwell's country doctor operating in a large metropolis as a "one-man machine": he was the physician, nurse, telephone operator, billing and appointment clerk, laboratory technician, and self-appointed consultant in matters of internal medicine. He was a witty storyteller who excelled in describing humorous personal events for the family; the annual Thanksgiving turkey carving became a replica of anatomical autopsies he had performed during his training in pathology. He also enjoyed describing his constant companion, the cervical collar, prescribed following an accidental fracture of a cervical vertebrae, which he maintained resulted from "too much necking" as a youngster. As a treating physician at the Baltimore City Jail, he contended that he treated more drunks than any other doctor in the city of Baltimore.

Dr. Acton's wife, Katherine, died in 1985. Survivors include three sons, Jonathan Acton, II, of Baltimore; Allan H. Acton of Towson, Maryland; Conrad H. Acton, Jr., of Orlando, Florida; and two grandchildren.

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Obituaries con't

JOHN HANS HIRSCHFELD, M.D., F.A.C.C.P.

A pulmonary specialist, bronchoscopist, and alcoholism activist, Dr. Hirschfeld performed approximately 15,000 bronchoscopies during his medical career; unfortunately, however, when he was scoped by Dr. Samuel Lumpkin in mid-October 1994, the biopsy disclosed a primary bronchogenic carcinoma. Subsequently, postlobectomy, he died in Florida, December 6, 1994, at age 81. He had not smoked for the past 20 years.

Born in Vienna, Austria, Dr. Hirschfeld received his medical degree in 1938 at the University of Vienna Medical Faculty. After graduation, he married Erna Liebermann, and together they came to the United States, where he interned from 1939 to 1940 at Bethel Hospital in Brooklyn, New York. He then spent five years as an assistant licensed physician at the Maryland State Tuberculosis Sanatorium in Sabillasville, where he learned about pneumothorax and bronchoscopic operations. He completed a postgraduate course in bronchoscopy at the University of Pennsylvania and became a fellow of the American College of Chest Physicians in 1947.

Although Dr. Hirschfeld originally had opened his office as a family practitioner on Harford Road in Baltimore, many of his former tuberculosis patients consulted him for follow-up procedures such as pneumothorax or thoracotomies. In addition to his general practice, he taught laryngology at the University of Maryland School of Medicine and performed bronchoscopies at Baltimore City Hospital, Church Home and Hospital, Mt. Wilson Sanatorium, and others.

With keen observation and insight, Dr. Hirschfeld and his cohorts noted the close comorbid relationship between pulmonary diseases and excessive use of alcohol, thereby creating an intense desire to diagnose and treat both illnesses, using different modalities of therapy. In December 1962, the Medical and Chirurgical Faculty of Maryland designated him as chairperson of the newly formed Subcommittee on Alcoholism; he remained a member of the full committee until his death. He was president of the Baltimore branch of the American Council on Alcoholism (BACA) from 1966 through 1969, and in 1973 he was honored by the National Council on Alcoholism with its Bronze Key Award. One of the highlights of his illustrious career occurred at the Lyric Theater on the night of March 30, 1981, when then-Mayor William Donald Schaefer presented him with the silver and blue "Baltimore's Best" award in recognition of his work in the field of alcoholism.

Dr. Hirschfeld was a member of the Baltimore City Medical Society, serving as a delegate to Med Chi from 1974 to 1978. A 40-year member of Med Chi, he also belonged to the American Medical Association, American Thoracic Society, International Broncho-Esophagology Society, American Society on Alcoholism, and BACA.

In 1981, Dr. Hirschfeld closed his office and discontinued making bronchoscopic examinations, but continued working part-time as a disability adjudicator for the Social Security Administration and member of the medical advisory board of the Maryland State Department of Motor Vehicles. He enjoyed attending symphony concerts as a reminder of his violin playing in the Vienna High School Orchestra. As an amateur photographer, he won a ribbon award from Med Chi for one of his black and white photographs. And who can forget his ambidextrous tennis antics? An expert player, he won his singles match in a recent Senior Olympics competition.

Despite Dr. Hirschfeld's outward appearance as a hard-driving, stern taskmaster, his true personality always encompassed sincere compassion for his patients, peers, and family members. He and his wife of 56 years raised and nurtured three children. Robert, of Phoenix, Arizona, and Leonard, of Philadelphia, Pennsylvania, both hold doctorates in electrical engineering from Massachusetts Institute of Technology. Their daughter, Judy Funk, of Coral Springs, Florida, has a bachelor's degree in education from Goucher College. Dr. Hirschfeld also is survived by a brother, Paul Hirschfeld of Scottsdale, Arizona; 3 grandchildren; and 3 great-grandchildren.

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Obituaries con't

ABRAHAM M. SCHNEIDMUHL, M.D.

An icon with 55 years of continuous and dedicated medical service, Dr. Schneidmuhl died on July 8, 1994. Born in Poland, he earned his medical degree in 1939 from the Medical School of the University of Nance, France. Shortly thereafter, he married Frances Korsez, who graduated from the same university as a dentist. During the next five years, as refugee itinerants, they lived in Vichy, France, as well as Spain and Portugal. Dr. Schneidmuhl ultimately served a one-year internship at the Women's General Hospital in Montreal, Canada, but as a refugee he was refused further training or certification in Canada. In 1946, he interned at a tuberculosis hospital in Little Rock, Arkansas. From 1947 to 1950, he was a resident at Maryland's Spring Grove State Psychiatric Hospital, following which he continued his psychiatric training with the Veteran's Administration at Perry Point and Baltimore. From 1951 to 1953, he worked at the Maryland Department of Health and Mental Hygiene's alcohol clinic in Cheverly. In 1953, he was board certified by the American Psychiatric Association and later became one of its lifetime fellows.

After establishing a private psychiatric practice, Dr. Schneidmuhl also worked for Baltimore City Health Department, where he directed the city's first outpatient treatment of alcoholics (1962). Indicative of his innovative leadership and organizational ability was his design and formation of the state's first training program for alcoholism counselors, which he founded in 1967. The program was so successful that it became a model for the undergraduate program for alcoholism counselors at The Johns Hopkins University (JHU) School of Hygiene and Public Health. In 1972, the newly created unit was headed by Dr. Wallace Mandrell, who described Dr. Schneidmuhl as a "home grown hero."

Dr. Schneidmuhl, who spoke six or seven languages, had a special aptitude for learning and teaching. At age 55, he earned his master's degree in public health at the JHU School of Hygiene. Thereafter, he taught and lectured about alcoholism at the School of Hygiene, the Veterans Administration, and the U.S. Armed Forces, including presentations in Alaska and the far east during the Vietnam War.

One of the founding members of Med Chi's Committee on Alcoholism, Dr. Schneidmuhl served on the committee for 32 years, attending meetings in 1994 until his death. He also was a consultant to the medical departments of the Baltimore & Ohio and Chesapeake & Ohio railroads, primarily to evaluate and treat alcoholic employees who operated train and locomotive services. In addition, he served as a psychiatric consultant to the Social Security Administration and the Medical Advisory Board of the Motor Vehicle Administration.

A gifted, multifaceted intellectual and humanitarian, Dr. Schneidmuhl was amiable and unobtrusive. His primary hobby was gardening; he also enjoyed music, the opera, and traveling. Aware of his terminal prognosis, Dr. Schneidmuhl relegated his physical impairments to a "back burner" with a firm determination to attend the graduation ceremonies of his two granddaughters in June 1994. By sheer "guts" and perseverance he traveled to Brandeis University in Waltham, Massachusetts, and one week later attended a similar ceremony at Brown University in Providence, Rhode Island. They were special occasions, for one of his granddaughters graduated magna cum laude, the other, cum laude. It was his last hurrah, and his reaction was typical—a brief movement of the lips, simulating a smile, accompanied by the scintillating, meaningful "twinkle in his eyes."

Three weeks following the graduations, Dr. Schneidmuhl died peacefully at age 81. In addition to his two grandchildren, survivors include his wife, Dr. Frances Schneidmuhl, and his daughter, psychiatrist Cecelia Shockett, M.D., who adroitly described her father as a "refined, elegant, tremendously warm person." And that he was.

ISADORE KAPLAN, M.D.

One of the founding members of the Addictions Committee and an emeritus member of Med Chi, Dr. Kaplan is retired from the Baltimore and Ohio Railroad, where he was medical director. ■

The Impact of Alcoholism on the Health Care System

What happens if alcoholics go untreated?

Subsequent lengthy and/or unsuccessful treatment is commonly required by the medical consequences of alcoholism; there is a gradual substantial rise in health care costs over time. Untreated alcoholics consume a disproportionate portion of total health care costs; they have a greater incidence of complications and prolonged hospital stays. One of every 4 dollars spent by Medicare and 1/5 by Medicaid on hospitalizations are attributable to alcohol or other substance abuse.[1-8]

What happens if alcoholics are treated?

Treatment of alcoholism significantly reduces the subsequent health care utilization and the cost of health care regardless of the age it is initiated; the younger the subject the greater the reduction; the subsequent health care need and costs are reduced to average levels if initiated before the age of 45. The savings continue for years and are equal for males and females. [1-6, 8-14]

How is the health care of the family of an alcoholic affected?

Spouses and children of alcoholics have as much as four times the use of health care facilities as the average of members of other families. The use of medical resources by family members shows a significant decline when the alcoholic is treated. In view of the large number of persons falling in this group, they seem to represent another preventable sizable drain upon our health care system.[2,4,5,15,16]

What can we do to impact the health care drain by alcoholics?

Early diagnosis and vigorous pursuit to convince the alcoholic to accept treatment and adequate funding for treatment of alcoholics taken together clearly represent relatively untapped resources which could significantly decrease overall health care expenditures in this country. This conclusion is based solely on health care cost data and does not take into account the personal tragedies and suffering, nor the societal costs of lost productivity, welfare, etc. which accompany this disease.[2-4,8,17,18]

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Tests for Rapid Screening of Patients for Alcohol Problems

A number of questionnaires have been designed to assist health care professionals in making the diagnosis of alcohol problems. Some that seem most suitable for office use include:

CAGE

A 4-question test widely used for quick screening, it has a sensitivity ranging from 60% to 95% and a specificity of 40% to 95%. Its chief limitation may be the questions' wording, suggesting to subjects that answers should be based on lifetime history rather than recent drinking patterns. Also, because questions about frequency of use, levels of consumption, or periods of heavier drinking are omitted, the test may miss a sizable proportion of patients in earlier stages of problem drinking. A number of longer tests with greater sensitivity and specificity also have been developed. Of these, the best known is the 25-question MAST test. Like the CAGE, it focuses on lifetime patterns of use rather than current patterns and thus also may fail to diagnose early problem drinkers. On the CAGE test, two positive answers are considered a positive test; further evaluation is indicated.

C Have you ever **cut down** on your drinking?

A Have people **annoyed** you by criticizing your drinking?

G Have you ever felt bad or **guilty** about your drinking?

E **Eye opener**: have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?

Source: Mayfield D, McLeod G, Hall P. The CAGE questionnaire: validation of a new alcoholism screening instrument. *Am J Psychiatry* 1974;131:1121-1123. Copyright 1974, the American Psychiatric Association. Reprinted by permission.

T-ACE

Specifically designed for use in pregnant women, the T-ACE is based on the CAGE but substitutes an important question for assessing tolerance. Two positive answers indicate the need for further assessment.

T **Tolerance**: How many drinks does it take to make you high? or How many drinks can you hold?

A Have people **annoyed** you by criticizing your drinking?

C Have you ever felt that you needed to **cut down**?

E **Eye opener**: Have you ever had a drink first thing in the morning?

Source: Sokol RJ, Martier SS, Ager JW. The T-ACE questions: practical prenatal detection of risk-taking. Am J Obstet Gynecol 1989;160:863-870. Used with permission.

Modifications for drug addicts

An ongoing study at the University of Maryland Shock Trauma Center indicates that the above tests have similar validity for diagnosing drug addicts when the questions are modified appropriately (e.g., Have you ever tried to cut down on your drugs? or Have you ever had to get high first thing in the morning?).

Alcohol Use Disorders Identification Test (AUDIT)

Developed by a WHO task force to assess alcohol use and alcohol-related problems over the past 12 months, AUDIT is a multicultural, 10-question test designed for use in primary care settings to screen for early-stage alcohol abuse. A cutoff score of 8 (possible score, 40) indicates problem drinking with a sensitivity of 92% and a specificity of 93%.

Circle the number that comes closest to the patient's answer.

1. How often do you have a drink containing alcohol?

(0) never (1) monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week

2.* How many drinks containing alcohol do you have on a typical day when you are drinking?
[CODE NUMBER OF STANDARD DRINKS]

(0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7 or 8 (4) 10 or more

3. How often do you have six or more drinks on one occasion?

(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

(0) no (2) yes, but not in the last year (4) yes, during the last year

10. Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested you cut down?

(0) no (2) yes, but not in the last year (4) yes, during the last year

* In determining the response categories it has been assumed that one "drink" contains 10g alcohol. In countries where the alcohol content of a standard drink differs by more than 25% from 10g, the response category should be modified accordingly.

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Reported practices, attitudes, and confidence levels of primary care physicians regarding patients who abuse alcohol and other drugs

Karen R. Duszynski, B.A., F. Javier Nieto, M.D., Ph.D., Carmine M. Valente, Ph.D.

Ms. Duszynski is director of the department of grants administration at the Medical and Chirurgical Faculty of Maryland; Dr. Nieto is assistant professor in the department of epidemiology at The Johns Hopkins University School of Hygiene and Public Health; and Dr. Valente is chief executive officer of the Private Practice Section of the American Physical Therapy Association.

ABSTRACT: *The American Medical Association recommends that physicians screen all patients for alcohol and other drug abuse so that substance-abusing patients can be referred for appropriate treatment. A 1991 survey of primary care physicians in Baltimore and Cumberland revealed that only 41% routinely screened their patients for alcohol problems and only 20% screened for other drug problems. These levels, as well as the levels at which Maryland physicians counsel, refer, and otherwise treat substance-abusing patients, are well below levels recommended by the AMA. The role that attitudes, confidence, and education play in determining physicians' practice patterns in regard to substance abuse is explored.*

More than 15 years ago, the American Medical Association (AMA) issued a set of guidelines regarding physician involvement in the care of substance-abusing patients.[1] The guidelines were organized into three levels, each involving increased responsibility. Physicians were asked to determine how much responsibility they chose to accept for their substance-abusing patients and to act in accordance with that level of responsibility. *All* physicians were asked to assume some responsibility. Recommendations for physicians choosing to operate at Level I, the minimal level of responsibility, included screening all patients for alcohol and other drug use so that substance-abusing patients could be referred as early as possible for appropriate substance abuse treatment.

In the years following publication of the guidelines, a number of studies documented the effectiveness of even brief interventions by physicians in reducing levels of substance abuse.[2-6] Although such studies emphasized

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Table 1. Questionnaire return rate

	No. Surveys Sent	No. Surveys Returned	(%)
Specialty			
family practice	186	118	(63)
general practice	130	76	(58)
internal medicine	421	243	(58)
obstetrics/gynecology	275	167	(61)
pediatrics	299	189	(63)
Gender			
male	994	619	(62)
female	317	174	(55)
Area			
Baltimore	1249	749	(60)
Cumberland	62	44	(71)

the utility of the guidelines, studies that examined the extent to which primary care physicians actually complied with the guidelines by screening, counseling, or following up with their substance-abusing patients were uniformly discouraging.[7-11]

Why do so few physicians seem to comply with the AMA recommendations? Underlying the recommendations is the assumption that physicians possess the requisite knowledge and skills to work with their substance-abusing patients. Such an assumption may be ill-founded. Substance abuse training was nearly nonexistent in medical schools until the 1970s,[12,13] and despite recent improvements,[14-17] many physicians now practicing may find themselves ill-prepared to follow even the requirements of Level I. Although successful educational programs in substance abuse for medical students and residents have been developed,[18,19] less attention has been focused on the development and evaluation of continuing medical education curricula.[20] And few studies have examined how such possible determinants as attitudes, education, and confidence levels are related to actual practice patterns.[21-23]

The Medical and Chirurgical Faculty of Maryland (Med Chi) investigated some of these areas when it undertook the development of a substance abuse education program for primary care physicians. As a first step in the development of the program, Med Chi conducted a survey of physicians in the Baltimore and Cumberland areas to determine their attitudes, medical practice patterns, and confidence levels in dealing with patients who abuse alcohol or other drugs. The aim of the survey was to assess the behavioral and educational level of these physicians in regard to substance abuse so that the education program could be directed to meet their specific needs.

Methods

Study Population. The target group for the survey included primary care physicians (family and general practitioners, internists, pediatricians, and obstetricians/gynecologists) in direct patient care. Regions of the state surveyed were the Baltimore metropolitan (urban) and Cumberland (rural) areas. Exact areas of the state covered were determined by U.S. Postal Service definitions. Names and addresses for all physicians meeting the above criteria were copied from the AMA Masterfile in September 1991. Additional information extracted from the Masterfile included each physician's medical specialty, gender, year of birth, and year of graduation from medical school. Distributions of the physicians by specialty and region were examined and a representative random sample was drawn of all specialties, except general practice, in the Baltimore metropolitan area. All general practitioners and all Cumberland physicians were surveyed to ensure adequate sample size.

The survey was conducted between November 1991 and February 1992. The first mailing of the questionnaire was sent to 1311 physicians. Each physician's questionnaire was encoded with a unique identification number so that repeat mailings could be made to nonrespondents. The key to the identification number was available to only one staff member. Two additional mailings were sent to nonrespondents at monthly intervals. Each mailing included a postage paid return envelope and a cover letter that endorsed the survey signed by the president of the medical society. A total of 793 physicians (60%) returned questionnaires. As shown in **Table 1**, there were no significant differences between those who returned a questionnaire and those who did not by medical specialty or region of the state, although somewhat fewer women returned questionnaires ($p = 0.02$).

Questionnaire. The questionnaire was broadly based on one used in a survey of medical students and house staff at The Johns Hopkins Medical Institutions regarding the diagnosis and treatment of alcoholism.[21] Items used here concerning attitudes were the same as those used at Hopkins, but modified to include use of drugs other than alcohol. For example, the statement, "People who become *alcoholics* are usually lacking in will power," was changed to "People who

become *substance abusers* are usually lacking in will power." Physicians were asked to indicate their degree of agreement with each statement on a 5-point scale, ranging from "strongly disagree" (scored as 1) to "strongly agree" (scored as 5).

After completing the attitude items, physicians were asked if they encountered patients who abused alcohol or other drugs in their practice. Physicians who denied encountering substance abusers were instructed to skip the questions regarding practice patterns, confidence levels, and education.

Physicians who indicated that they saw substance abusers were asked how often (never, rarely, sometimes, usually, or always) they screened patients, counseled patients, counseled patients' families, referred, used drug therapy, and provided educational materials regarding alcoholism. "Never" was scored as 1 and "always" was scored as 5. Parallel questions were asked separately for other drug abuse.

Confidence items were presented in the form of a statement (e.g., "I know how to screen effectively for alcoholism") and physicians were asked to indicate their degree of agreement on a 5-point scale (strongly disagree=1, strongly agree=5). Physicians were asked to rate their confidence in screening, counseling, and referring for alcoholism and then to rate separately their confidence in the same areas for other types of drug abuse.

In regard to level of training, physicians were asked to estimate the number of hours of substance abuse education they had received in medical school, in residency training, and each year in continuing medical education. They were also asked how many hours of substance abuse education they recommended for medical students, for residents in their specialty, and for license renewal.

Statistical analyses. Principal components-type factor analysis followed by orthogonal rotation was performed separately on items concerning attitudes, practice patterns, and confidence; the scree test was used to determine the number of factors retained.[24,25] Three factors captured 54% of the total variance in the attitude data set. These factors were labeled *substance abuse is a bad habit*, *substance abuse is a treatable disease*, and *physicians should diagnose and refer*. Two factors that captured 47% of the total variance were identified in the practice pattern data set. These factors were named *physician treatment* and *refer*

Table 2. Items and reliabilities for each factor scale

Attitude scales	Cronbach's Alpha
■ Substance Abuse Is a Bad Habit (8 items):	.83
▪ Substance abusers are morally weak.	
▪ Substance abusers are spineless.	
▪ Substance abusers lack willpower.	
▪ Substance abuse is a habit, not an illness.	
▪ Substance abusers are poorly educated.	
▪ Substance abusers are usually unemployed.	
▪ Substance abusers enjoy abusing substances.	
▪ Substance abuse is not a disease.	
■ Substance Abuse Is a Treatable Disease (5 items):	.84
▪ Alcoholism is a treatable disease.	
▪ Drug addiction is a treatable disease.	
▪ Group therapy is important to treatment.	
▪ Paraprofessionals are effective counselors.	
▪ Family involvement is important to treatment.	
■ Physicians Should Diagnose and Refer (4 items):	.72
▪ Early diagnosis improves treatment success.	
▪ Physicians should refer for treatment.	
▪ Urine screening is important to treatment.	
▪ Substance abuse is a major health problem.	
Practice pattern scales	
■ Physician Treatment (10 items)*:	.90
▪ Screen for alcohol/drug problems.	
▪ Counsel patients about alcohol/drug problems.	
▪ Counsel patient's family about alcohol/drug problems.	
▪ Provide educational material about alcohol/drug problems.	
▪ Follow-up with alcohol/drug abusing patients.	
■ Refer for Treatment (2 items)*:	.82
▪ Refer patients with alcohol/drug problems for treatment.	
Confidence scale	
■ Confidence (6 items)*:	.89
▪ Screen effectively for alcohol/drug problems.	
▪ Good at counseling patients with alcohol/drug problems.	
▪ Appropriate referrals for alcohol/drug problems.	

*Alcohol/drug asked as separate questions.

for treatment. Factor analysis of the confidence items showed a single factor, called simply *confidence*, which accounted for 65% of the total variance. Items included in each of the factors were summed into simple scales. **Table 2** lists the items included in each of the scales as well as the reliability coefficient (as measured by Cronbach's alpha) associated with each scale.[26] Items and scales were examined using both para-metric and nonparametric procedures; since results were essentially the same, only the parametric procedures are presented here. Parametric procedures used included correlated t-tests, analyses of variance, and Pearson's product-moment correlations.

Results

Respondent characteristics. Average age of the 793 respondents was 47.81 years. Eleven percent indicated that they were in hospital-based practice; 40% were in solo practice; 29% in group practice; and 20% in other types of practice (HMO, public clinic, military). Preliminary comparisons showed no significant differences between physicians in the Baltimore metropolitan and Cumberland areas on education levels or on any of the attitude, practice pattern, or confidence scales. The two groups were therefore merged for the present analyses.

Attitudes toward substance abuse. Attitude scores overall indicated that the majority of physicians surveyed tended to agree with the disease model of addiction and to disagree with the idea that substance abuse is no more than a bad habit. Average score on the *substance abuse is a treatable disease* scale was 4.24 (95% confidence interval [CI] 4.20-4.28); 81% of the physicians scored in the "agree/strongly agree" range (4 or 5). Similarly, 75% scored in this range on the *physicians should diagnose and refer* scale (mean = 4.09, 95% CI 4.05-4.13). Conversely, average score on the *substance abuse is a bad habit* scale was 2.38 (95% CI 2.33-2.43); the majority of physicians (62%) scored in the "disagree/strongly disagree" range.

Practice patterns. Of the 793 physicians who responded to the questionnaire, 190 (24%) said they did not encounter alcohol or other drug abuse in their practices. Findings in regard to practice patterns, confidence levels, and education are therefore restricted to the 603 physicians who indicated that they encountered substance-abusing patients.

Average score on the *physician treatment* scale was 3.04 (95% CI 2.97-3.10) and only 12% of these physicians fell within the "usually/always" (4 or 5) range of this overall measure of physician involvement. Average score on the *refer for treatment* scale was much higher, 4.10 (95% CI 4.04-4.17), and 75% of the respondents scored in the "usually/always" range.

Analyses regarding individual practice activities are summarized in **Table 3**. The activity physicians reported performing most frequently in regard to substance-abusing patients was referral. Correlated t-tests performed between each alcohol item and its parallel drug item showed that physicians significantly more frequently screened, counseled patient and family, followed up, and used drug therapy in regard to alcohol than to other drugs.

Table 3. Practice pattern and confidence items for alcohol and other drugs, Maryland physicians, 1991-92

	Alcohol		Other Drugs		t-test
	Mean	95% CI*	Mean	95% CI	p value
Practice Patterns**					
screens	3.02	2.91-3.12	2.40	2.30-2.49	<0.001
counsels patient	3.65	3.56-3.73	3.42	3.33-3.51	<0.001
counsels family	2.97	2.88-3.06	2.87	2.77-2.95	<0.004
refers for treatment	4.04	3.97-4.11	4.17	4.10-4.25	<0.001
follows up	3.42	3.33-3.51	3.31	3.21-3.40	=0.001
uses drug therapy	2.22	2.12-2.31	1.45	1.38-1.51	<0.001
educational material	2.63	2.53-2.72	2.65	2.56-2.75	NSD
Confidence in***					
screening skills	3.25	3.17-3.33	2.97	2.89-3.05	<0.001
counseling skills	2.62	2.54-2.70	2.39	2.32-2.47	<0.001
referral skills	3.31	3.23-3.39	3.14	3.06-3.23	<0.001

* CI = confidence interval

** 1 = never, 2 = rarely, 3 = sometimes, 4 = usually, 5 = always

*** 1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree

Table 4. Mean substance abuse education hours in medical school and residency by year of graduation from medical school, Maryland physicians, 1991-92

Year of Graduation	Hours Received:				Hours Recommended:			
	Medical School		Residency		Medical School		Residency	
	Mean	95% CI	Mean	95% CI	Mean	95% CI	Mean	95% CI
■ ≤ 1959	3.01	1.27-4.75	0.34	0.05-0.62	24.16	20.09-28.23	25.02	20.73-29.31
■ 1960-1969	2.82	1.92-3.72	3.54	2.03-5.06	26.88	22.40-31.36	25.56	21.06-30.06
■ 1970-1979	8.80	6.28-11.32	14.41	9.24-19.57	33.06	28.61-37.51	44.01	30.16-57.86
■ 1980-1988	14.24	10.75-17.72	20.31	13.93-26.69	31.36	25.99-36.74	33.73	28.28-39.17
TOTAL	7.68	6.37-8.99	10.68	8.26-13.10	29.39	27.02-31.75	33.17	28.56-37.78
p	<0.001		<0.001		= 0.04		= 0.01	

Confidence levels. Only 10% of the respondents fell within the "agree/strongly agree" range on the overall *confidence* scale and average score was 2.95 (95% CI 2.89-3.01). Results of analyses performed on individual confidence items are presented in **Table 3**. For both alcohol and other drugs, physicians were most confident in their ability to refer and least confident in their counseling skills. Correlated t-tests between each alcohol item and its paired drug item showed that physicians were significantly more confident in dealing with alcohol than with other drug abuse.

Education. Analyses of hours of education in medical school and residency are summarized in **Table 4**. Physicians who graduated before 1970 received significantly less substance abuse education in medical school and during residency training than those who graduated in later years. All groups recommended many more hours of education than they had themselves received; those who had received the most education in medical school and residency recommended even higher levels of education than those who had received the least education. Overall, correlated t-tests between number of hours of substance abuse education received versus number of hours recommended were highly significant for both the medical school ($p < .001$) and residency ($p < .001$) comparisons.

Table 5 shows a significant difference across graduation years in number of hours of continuing medical education received each year; respondents who graduated in 1970-1979 received the greatest number of hours and those who graduated in 1980-1988 received the least. There was no significant difference in number of hours of substance abuse education recommended for license renewal.

Association between variables. Pearson product-moment correlation coefficients between the practice pattern scales and the attitude, confidence, and education measures are presented in **Table 6**. Both of the practice pattern scales were most highly correlated with the *confidence* scale, although *refer for treatment* was correlated at a much lower level than *physician treatment*. The *refer for treatment* scale also was significantly correlated with two attitude scales, *physicians should diagnose and refer* and *substance abuse is a treatable disease*. Although *refer for treatment* was not related to any of the education variables, both hours of continuing medical education and hours of education received in residency training

Table 5. Mean continuing medical education hours in substance abuse and hours recommended for license renewal by year of graduation from medical school

Year of Graduation	Hours Received Each Year		Hours Recommended for License Renewal	
	Mean	95% CI	Mean	95% CI
■ ≤ 1959	3.89	3.00-4.78	4.20	2.53-5.87
■ 1960-1969	3.96	2.76-5.17	3.04	2.12-3.97
■ 1970-1979	5.87	3.85-7.89	3.27	2.24-4.30
■ 1980-1988	3.24	2.25-4.24	2.60	2.03-3.18
TOTAL	4.34	3.59-5.09	3.23	2.70-3.75
p	= 0.05		NS	

Table 6. Correlation coefficients between practice pattern scales and attitude and confidence scales and hours of substance abuse education

Predictor Measure	Physician Treatment Scale	Refer for Treatment Scale
■ Attitude scales:		
▪ Substance Abuse Is a Bad Habit	-0.15	NS
▪ Substance Abuse Is a Treatable Disease	0.16	0.19
▪ Physicians Should Diagnose and Refer	NS	0.24
■ Hours education received:		
▪ In medical school	NS	NS
▪ In residency	0.15	NS
▪ Per year	0.23	NS
■ Confidence scale	0.62	0.28

All correlations statistically significant at the 0.001 level.

were significantly correlated with the *physician treatment* scale.

There were also some significant associations among attitude, confidence, and education variables. The *substance abuse is a bad habit* scale was negatively related to both hours of education received in medical school ($r = -0.12$, $p < 0.01$) and hours of continuing medical education ($r = -0.13$, $p < 0.01$), while the *substance abuse is a treatable disease* scale was related only to the *confidence scale* ($r = 0.12$, $p < 0.01$). The *confidence* scale also was significantly correlated with hours of continuing medical education per year ($r = 0.28$, $p < 0.001$).

Discussion

Review of the literature indicates that physicians' attitudes toward substance abuse have changed over time. Studies in the early 1970s, for example, show physicians in private practice believing that personality or emotional factors cause alcoholism[27] and psychiatrists rejecting the disease concept of alcoholism.[28] By the late 1980s, however, surveys of primary care physicians showed that 86% to 89% believed that alcoholism is a disease.[22,29] In the present analysis, 90% of the physicians surveyed not only agreed that alcoholism is a disease, but that alcoholism is a *treatable* disease; in addition, 88% agreed that drug addiction is a treatable disease.

Despite more positive attitudes toward substance abuse, however, the majority of physicians surveyed were not screening routinely for substance abuse. In a previous study, physician estimates of the number of substance-abusing patients in their practices were well below rates in the general population.[30] Nearly a quarter (24%) indicated that they did not encounter any substance-abusing patients in their practices. Of those who said they encountered substance abuse, only 41% indicated that they screened for alcohol abuse with any regularity, and only 20% screened for other drug use. These findings parallel those reported in other recent studies.[7,31-33] Evidence that physicians who do screen are not screening *effectively* is equally abundant; most investigators have found that physicians are generally more likely to screen certain types of patients and to identify only the most serious substance abuse problems.[8-10]

Coupled with failure to screen for substance abuse is a tendency for physicians to avoid speaking with and counseling patients they do identify as substance abusers. A 1991 survey showed that only 34% of primary care physicians in North Carolina routinely counseled and/or referred patients with alcohol problems and only 50% did so for patients who abused other drugs.[34] In another study involving employees identified on the job as having alcohol problems, only 22% could recall having been warned by a physician to modify their alcohol intake.[6] A third investigation showed that physicians counseled only 67% of their alcohol-abusing patients, even though they tended to identify only those with the most serious problems.[10] The current investigation yielded similar findings; 62% of surveyed physicians indicated that they usually or always counsel their patients with alcohol problems, and 51% counsel those who use other drugs.

What is needed to increase the frequency with which primary care physicians screen and counsel for substance abuse? Several studies have examined the relationship between practice patterns and measures of attitudes, confidence, and education.[21-23,31] Attitudes have inconsistently been found to have a significant relationship to practice patterns.[21-23] In the current study, although attitude scales were significantly correlated with practice pattern scales, the single most important predictor variable by far appeared to be confidence: the *confidence* scale

accounted for 38% of the variability in the *physician treatment* scale.

It seems reasonable to assume that education plays an important role in building both confidence and attitudes,[35] an assumption borne out by the significant correlations between education— particularly continuing medical education—and the attitude and confidence scales. Although several investigators have emphasized the importance of training in clinical skills,[21-23] the question of knowledge- vs. experience-based education was not addressed in the present investigation. What was addressed is what might be called recency of education, with the most recent education, continuing medical education, showing significant correlations with attitudes and confidence as well as with practice patterns. There is some evidence that the relationship between recency of education and knowledge levels holds true in areas other than substance abuse.[36,37]

Continuing education takes many forms, including formal curricula, journal articles, public service announcements, and discussions with colleagues and patients.[38,39] In developing its substance abuse education program, Med Chi has used a variety of media. Three formal curricula have been developed to meet the specific needs of local physicians. The first, developed in 1992, is an overview of treating the substance-abusing patient and was designed to provide the basic knowledge necessary to develop further skills. Taught by physician-educators, the program has been presented to more than 1500 physicians in various settings (hospitals, conferences, community health centers, health departments) throughout Maryland. To reach as many physicians as possible, the curriculum was reformatted as a self-study guide in 1993/94 and offered to every primary care physician in the state.

A second curriculum, developed in 1993, focuses on heroin and other opioids. Med Chi deems this curriculum especially timely in view of rising rates of heroin abuse in Baltimore and Prince George's County and the risk of human immunodeficiency virus (HIV) infection attendant on injection drug use. The most recent curriculum designed is an experiential program in how to talk with and counsel substance-abusing patients.

Formal curricula, however, are not the only tools Med Chi is using in its education program. A special issue of the *Maryland Medical Journal* (January 1994) was dedicated to physician treatment of substance-abusing patients. In addition, some of the results of the needs assessment survey (which are educational in themselves) have been disseminated through specialty society newsletters, speeches, and a previous article in the *Maryland Medical Journal*.[30]

Physician response to Med Chi's efforts has been gratifying. More than 90% of those who attended a presentation of one of the formal curricula indicated that they would recommend the program to their colleagues. Comparisons of pre- and post-presentation practice patterns show significant increases in the frequency of screening and counseling for those physicians who attend an education program.

A 1987 survey of Los Angeles physicians showed that 62% agreed that alcohol abuse could be reduced if physicians took a more aggressive role in diagnosing and treating their alcoholic patients.[40] In the same survey, only 15% believed they were doing all they could in working with their patients' alcohol abuse problems. In the current study, the vast differences between the amount of education physicians received and the amount they recommended in both medical school and residency attest to their understanding of the need for more education in dealing with their substance-abusing patients.

A definitive substance abuse education program does not exist. As the picture of substance abuse in our society changes, and as physicians' skills in dealing with substance-abusing patients improve, so the educational needs of physicians will change. Although there is a continuing need to develop and deliver timely substance abuse programs, physicians must be willing to take advantage of the educational programs available to them.

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Physician interventions in alcoholism—past and present

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ABSTRACT: *Controversy over how physicians could address the public and private agonies inflicted by alcohol-related disorders has remained active throughout American history. Public and professional attention during the past quarter century has focused primarily on the identification and referral for treatment of the alcohol-dependent or alcoholic individual. Recent controlled research into medical intervention has shown that primary care physicians have an important opportunity to reduce the severity of alcohol-related problems at many points along their course and can provide effective care in the office setting. This article describes how these interventions have developed and highlights their importance in the context of recent changes in health care delivery systems.*

The current crisis in health care costs, seen by many as an impending disaster for the helping professions, is actually the means by which a culture forces itself to face painful choices. The positive results of such a re-examination of our therapies can be better treatment for our patients as we try to work smarter hours, not just longer ones. Part of that search will be to change our assumptions about how we may best treat many illnesses, especially chronic disabling disorders like substance abuse.

Alternative treatments for behavioral disorders, including the treatments for drug and alcohol abuse disorders, have been under intensive study for the past decade. One result has been the affirmation that there is a central role for interventions by primary care physicians. The data suggest that a large percentage of individuals who are at risk for alcohol

The opinions expressed in this article are those of the author and do not reflect the official policy of the Food and Drug Administration, the Department of Health and Human Services, or the federal government.

dependency syndromes (or who are in its earliest stages) can modify their behavior if appropriately motivated and assisted in doing so. Armed with these findings, it may be possible for physicians to improve markedly their personal effectiveness in preventing, modifying, and treating alcohol-related disorders.

Treatments for (the) alcoholism(s)

Unsolved scientific or medical problems are often the subject of competition among different innovators or groups of innovators, each proposing a theory or treatment that often claims to be exclusive (the *only* way) and which may denigrate alternative theories. This certainly seems to be the case with alcohol use disorders, which have been subjected to a complex stream of theories of etiology and management.

Hygenic reforms. During the late nineteenth and early twentieth centuries, many considered alcohol a toxic drug of abuse that was directly responsible for great suffering among the poor, with consequent abuse and deprivation of women and children. The ready availability of alcohol was considered to be the social problem, and the solution was national prohibition. Prohibition was ultimately rejected by the public, primarily because of adverse consequences resulting from the development of a large, highly profitable black market (as is seen with narcotics today).

Heavy use years, 1950-1970. Alcohol use in America accelerated with prosperity after World War II and reached an historical maximum in the 1960s.[1] Alcohol use was promoted by the alcoholic beverage industry as a "positive" behavior toward which individuals should aspire, much as cigarette smoking was promoted by the tobacco industry. Intoxication, alcohol abuse, and alcohol dependence were recognized, but were considered to be distortions of normal behavior due to symptoms of a concurrent psychological disorder or deficiency of character. Alcohol use disorders were managed as what today would be described as lifestyle illnesses and/or secondary complications of a primary psychiatric disability.

The rise of 12-step programs. In the late 1950s and 1960s, a growing number of physicians and other health care professionals were encouraged by the success of the lay organization Alcoholics Anonymous (AA), a 12-step program that provided for community-based support of abstinence from alcohol. Focusing on relapse prevention rather than detoxification, AA and similar programs are based on a foundation of abstinence followed by a program of psychological and spiritual recovery.

AA grew explosively during the post-war years. The widespread alcohol use of the 1950s and 1960s led to a high prevalence of chronically alcohol-dependent individuals in the 1970s, and the "medical model" of alcohol use disorders emerged.[2] Large military and occupational programs embraced and promoted a 28-day program of inpatient rehabilitation (based on the Hazelden or the "Minnesota" Model), which used AA meetings as the major relapse-prevention element. These programs were highly successful and had 2-year remission rates for program graduates ranging from 65% to 85%, depending on prognosis.[3]

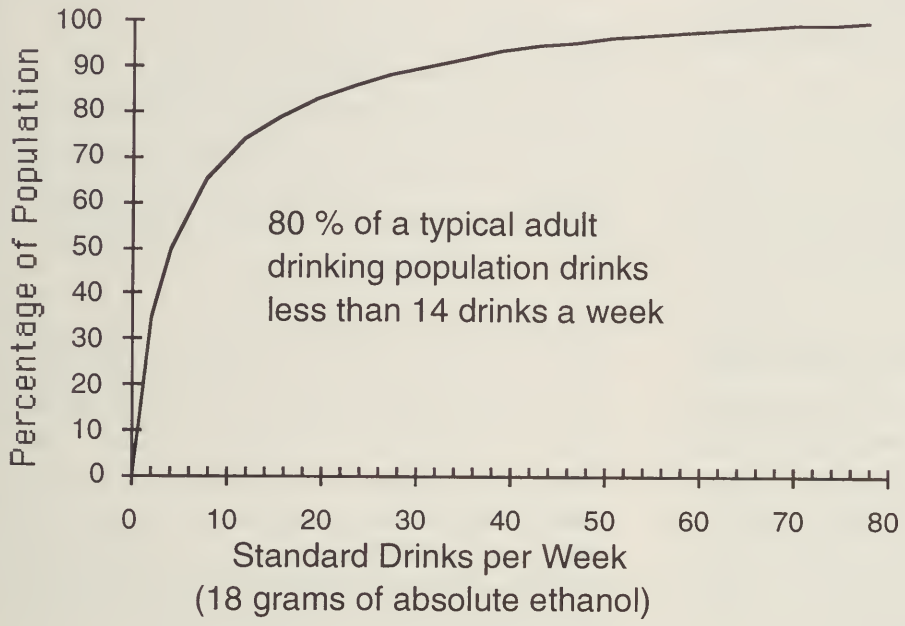
The political years, 1965-1975. By the mid-1970s, recovering alcoholics had developed the same political force we have seen displayed in recent years by AIDS activists. They had a national organization (the National Council on Alcoholism), major new legislation (the Hughes Act of 1970), a National Institute on Alcohol Abuse and Alcoholism (NIAAA), and a growing rehabilitation industry. Inclusion of alcohol abuse and alcoholism as primary disorders in the emerging *Diagnostic and Statistical Manual of Mental Disorders* (DSM II-IV) and other state and federal initiatives led to alcohol use disorders being considered insurance reimbursable conditions in many states.

The boom years, 1975-1985. During this period, there was an explosive growth in residential alcohol programs. Both the complexity and cost of 28-day inpatient treatment increased as the farms and converted road houses of the 1950s and 1960s were replaced by full-service residential facilities complete with accreditation standards.

Clinical emphasis, however, remained on the treatment of alcohol dependence in individual patients. Over time, the pool of mature "primary" alcoholics (those with a good prognosis and high socioeconomic status who were most responsive to this therapy) began to shrink. Programs began to admit individuals with poorer prognoses, diminished community resources, or secondary or "dual" diagnoses. These patients went through two, three, or more inpatient treatment episodes without apparent effect, a fact that was not lost on public policy analysts. Although many of these patients did recover, external observers began to question the wisdom of third party payment, especially in an atmosphere of growing concern over health care costs.

Concern over cost and external controls, 1985-1990. From 1970 to 1980, the cost of alcoholism services grew at an annual rate of 10% to 15%. When coverage became a mandatory part of health insurance and a major cost item, it came under the direct scrutiny of the emerging cost containment movement. In 1986, three articles regarding the treatment of alcoholism reached very different conclusions. Holder and Hallan[4] presented results of a six-year utilization study that showed a dramatic reduction in health care expen-

Figure 1. Cumulative distribution of alcohol use



ditures for alcoholics and their families following (predominantly inpatient) treatment. At the same time, Miller and Hester[5] and Annis[6] reviewed efficacy data suggesting that the inpatient treatment (rehabilitation) model was no more effective than outpatient models of care.

The controversy deepened and widened as the emerging inpatient rehabilitative services industry became increasingly dependent on third party funding. One result was an explosion in research: there are now more than 600 on-line reports of outcome studies of alcoholism treatment in the world's experience. In a summary of the literature, the Institute of Medicine concluded: "No one form of treatment is likely to be effective for all persons with alcohol problems. . . . A principal task in providing treatment is to identify the kind of treatment that is most likely to prove effective for a given person with a given problem."[7]

At the crossroads, 1995. It is clear that there is a limit to how much financial and human capital we can spend on the direct delivery of treatment services at the expense of other sectors of our economy. We all must face the problem of resource allocation at the bedside, in the clinic, and at the laboratory bench. In the case of alcoholism, the outcome of cost restraints may be more effective treatment. Shifting the emphasis from intervention in cases of alcohol dependence to other points in the natural history might improve the outcome for the population. To do so, however, we will have to match the intervention not only to the severity of the illness, but to the natural history of the alcohol use disorders.

Natural history of alcoholism in America

Use patterns. In America, alcohol use is initiated in childhood, usually in the early adolescent years (ages 12 to 15). Among high school seniors, 50% to 60% report current alcohol use and 30% to 40% report heavy drinking (more than five drinks at a single sitting during the past 2 weeks).[8] Although a shocking statistic for a population that is forbidden by law from purchasing alcohol, it is lower than the 1980 peak.

Adolescent users show increasing consumption that peaks during the late teens or early twenties. There is likely to be one or more alcohol-related episodes of social dysfunction, such as an arrest for driving while intoxicated. Maturing drinkers begin to moderate heavy adolescent drinking by the time they reach their thirties. For normal-risk individuals, adolescent substance use is a period of risk to be traversed en route to a stable adult pattern of behavior. The major risks for adolescent drinkers are vehicular accidents, suicide-homicide-assaults, boating-sports-firearms injuries, impulsive criminality and high risk sexual behavior.[9] There is, however, a group of high-risk children[10] characterized by a high latitude racial vulnerability (Northern European, Celtic, Native American, Eskimo), parental alcoholism, early school and conduct disorder, abuse and neglect syndromes, and early tobacco addiction.

Most adult alcohol users control their use, drinking less than four drinks on any occasion and drinking on less than three occasions per week. **Figure 1** shows data cited by Vaillant[11] indicating how most adult drinkers limit their consumption. Alcohol consumption declines with age, decreases with increasing social status, and decreases with increasing health consciousness. The overall pattern is one of declining alcohol use as young, normal drinkers mature, which contrasts with a pattern of increasing use in patients with emerging alcohol use disorders.

Entry into treatment. Time of first entry into alcoholism treatment is usually heavily affected by external factors and the social context. Referral usually follows a driving infraction, workplace conflict, incident of domestic violence, or

alcohol-related illness or injury (often vehicular). Most individuals with alcohol use disorders begin to enter treatment in the third and fourth decades of life, and the median age of referral is between 30 and 40, depending on the population served.

The efficacy of treatment varies according to the personal and social resources of the patient, the contingencies faced, the presence or absence of concurrent psychiatric disorders, the treatment resources available, and the skill of the therapist(s). Because alcohol-associated disorders cluster with sociopathy, drug use, unemployment, and most recently with human immunodeficiency virus (HIV) disease, how well treatment works depends on who is being treated. Data from studies of employee assistance programs indicate that remission can be established following inpatient or high-intensity outpatient treatment for 50% of patients per treatment cycle for general workplace populations, 75% to 85% of good prognosis patients, and 25% or less of poor prognosis patients with multiple disabilities, including associated behavioral or drug use disorders.[3]

Simple referral to Alcoholics Anonymous is a weak therapeutic intervention, but it is a free and readily available relapse prevention program. Twelve-step programs like AA are very effective in preventing relapse in patients who find them acceptable and continue to attend.[12] Occupational programs using AA as the foundation for relapse prevention are generally successful, but usually augment the program with professional treatment. The best testimonial for a treatment program is that it is one physicians choose for themselves (e.g., Maryland impaired professionals program).

Given the natural history of alcohol use disorders, potential points of intervention are the establishment of appropriate social norms for safe use of alcohol; the discouragement of alcohol use among high-risk individuals; identification and intervention in incident and prevalent cases; and application of a menu of effective treatments, including appropriate relapse prevention and rehabilitative services.

Promoting sensible alcohol use

The alcoholic beverage and entertainment industries are deeply conflicted about the promotion of alcoholic beverages. On one hand, they experience and publicize the horrors of alcohol use disorders; on the other, heavy drinkers constitute the market for almost half the alcoholic beverages consumed. Marketing aimed at young adults can be highly attractive to adolescents, and although direct or indirect sales to minors is illegal, they are a significant source of revenue for both manufacturers and retailers.[8]

Table 1. Elements of successful brief interventions

- Accurate feedback of personal risk, impairment, or injury
- Emphasis on personal responsibility for change
- Clear advice on specific goals for change efforts
- Provision of written materials with a menu of change methods
- Expression of confidence in the patient's ability to change
- Extension of an opportunity for one or two follow-up visits

Physicians can and should take the position that children should *not* use alcohol, drinking in school-age children is *not* normal, alcohol should *not* be served at school-age parties, and sales of alcohol to school-age children *is* criminal behavior. The goals of age limitations are to get a greater percentage of adolescents through the vulnerable years alive and to push initial alcohol use into an age range where increased maturity and a higher level of social expectations come into play to promote responsible use.

Physicians, however, should not neglect adults. As discussed below, medical professionals play an important part in establishing safer alcohol use. Adults who use alcohol may need help to establish quantity-frequency guidelines for their drinking and education in the importance of avoiding use of alcohol as self-medication and the relationship of alcohol to sleep, mood, and other health problems.

Families at risk

Alcohol use clusters with sexual, spouse, and child abuse and is a critical element in many accidents, suicides, and homicides.[13] Physicians who work with school, social, and legal programs need to include alcohol counseling in their practices. Helping those at risk understand the relationship between drinking and loss of control over conduct is an important means of reducing the risks from domestic violence in homes where alcohol is abused.

Individuals at high risk of alcohol dependence need a different strategy. In screening for children at risk, no test yet available is more accurate than the triad of a family history of alcoholism; abuse, school or conduct problems; and early tobacco use. Children of alcoholics need early intervention (ages 10-14). The best strategy is to help at-risk children identify the role of alcohol in their family's problems; provide them with access to educational, interventional, and community-based intervention programs; and encourage them not to drink. It is difficult to ask adolescents to act differently from their peers, but a matter-of-fact approach

similar to that used in the management of diabetes or phenylketonuria is appropriate.

Brief interventions

A number of studies have supported the role of a brief medical intervention by a physician as an alternative to more conventional rehabilitative therapy.[14] Outcome in general populations varied with the intensity of the intervention, but there was a substantial effect even when the intervention was brief and delivered as a part of routine health care. The elements of a successful brief intervention reported by Bien[14] are shown in **Table 1**. These elements were developed into the *Alcohol Risk Assessment and Intervention Resource Manual for Family Physicians* available from the College of Family Physicians of Canada. Their *Ask, Assess, Advise and Assist* model of intervention, which is appropriate to office and hospital practice, is shown in **Table 2**. Similar models are under development in the United States by the National Institutes of Health.

Brief interventions appear to be most valuable to heavy drinkers at risk of alcohol dependence, and less effective than more traditional rehabilitation in the case of alcohol-dependent individuals over the age of 40. Since they take place in the context of an already scheduled health care visit, are brief, and involve at most one or two follow-up visits, they appear to be a health care utilization bargain. Patients can be provided with good information about their risk with respect to the general population, specifically advised that they have both the obligation and the ability to modify their risk, and provided a menu of choices of what to do about it. Up to 20% of heavy drinkers may take action to lower their risk, and many will take lasting action after such counseling.[14] For alcohol-dependent patients, records regarding a brief intervention may be valuable in later attempts to bring them into more intensive treatment.

Referral and rehabilitative treatment

Research in the management of substance use disorders suggests that classification of treatment services (inpatient/outpatient/community) by the *place* of treatment is less important than the kind, frequency, and intensity of the treatment provided. Important new tools include outpatient detoxification of younger alcoholics, short-term use of supervised disulfiram (Antabuse) in outpatient treatment, evening outpatient programs for the employed, and day hospitalization programs. Physicians can improve patient acceptance of treatment by providing an individualized menu of choices. The next decade may hold some promising new medications, such as the recently approved drug naltrexone (ReVia), which appears to make outpatient treatment more effective.

Table 2. Family physician's model

- ASK about alcohol use.
- ASSESS quantity, frequency and risk of the patient's drinking.
- ADVISE about the facts, risks, and consequences of drinking behavior.
- ASSIST the patient in selecting from a menu of interventions.

Individualization of care and third party controls

In patients with established alcohol dependence, management will be chronic. For many patients, intervention, treatment, relapse management, and establishment of a stable pattern of recovery is a multi-year process. A third party case manager with access to a patient's long-term records of health care utilization may have information about the patient's prior history that is helpful to the treating physician. If the physician and the third party payer can communicate effectively and form a therapeutic alliance, the patient will benefit.

The increased availability of high-intensity (and high-cost) alcoholism services has led to increased demand for and use of those services. The same forces that have led to inappropriate use of laboratory tests, investigational treatments, and subspecialist services have led to the use of residential treatment for early alcohol use disorders. As a result, benefits have been limited and precertification imposed.

In the case of alcohol use disorders, individual patients may suffer from anything ranging from a bad habit under volitional control to a disabling compulsive disorder. As physicians, we must prevent, recognize, assess, assist, intervene, and refer appropriately. To do so requires using educational materials, community outreach, brief interventions, family interventions, outpatient detoxification, inpatient detoxification, and outpatient and inpatient rehabilitation as appropriate to each *individual* patient. If we tailor treatment to the patient's needs rather than use procrustean manipulations to fit the patient to our treatment philosophy, we will have enough resources to treat all patients.

Primary care practitioners can help the community re-establish healthy norms, help parents and schools re-establish defenses against drug and alcohol abuse by the young, intervene with

those at risk, and provide a rich choice of pathways to recovery to those suffering from alcohol use disorders. Substance use disorders are perhaps the best example of our obligation to be more than just caregivers and serve to remind us to share the benefits of our knowledge to the betterment of the health of all our patients.

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WOMEN, DRUG ABUSE, AND AIDS

- Almost half of all women aged 15 to 44 have used illicit drugs at least once.
- Among women aged 12 and older, 10.3 million have used at least one illegal drug during the past year.
- More than 4.4 million women aged 12 and older currently use illegal drugs.
- During the past year, 4 million women took prescription drugs nonmedically.
- In 1992, an estimated 221,000 women who gave birth in the United States used illicit drugs during pregnancy.
- AIDS is the fourth leading cause of death among women aged 25 to 44 in the United States.
- More than 34,000 of the AIDS cases among women (67%) are drug related.

Sources: 1993 National Household Survey on Drug Abuse; NIDA National Pregnancy and Health Survey; Centers for Disease Control and Prevention *HIV/AIDS Surveillance Report*, June 1994.

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Addictions training for physicians and other licensed health care professionals in Maryland

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ABSTRACT: *Physicians and other health care providers have multiple opportunities in the course of a typical practice year to identify and treat individuals who abuse alcohol and other drugs. Although substance abuse is very common in clinical practice, providers routinely fail to intervene in a timely fashion due to negative attitudes, incomplete knowledge, and poorly developed practice skills. Over the past ten years, addictions training of licensed health care providers nationally and in Maryland has improved significantly. This article describes recent national training trends and current educational programs statewide for medical students, physicians in residency and fellowship programs, and licensed providers in dentistry, nursing, pharmacy, psychology, and social work. Several strategies for improving professional training in addictions in the future are discussed and the importance of shifting to an interprofessional training model is emphasized.*

The abuse of alcohol and other drugs is common in the general population and among the medically ill. Recent studies document high current and lifetime prevalence rates in several different populations.[1-5] The Epidemiological Catchment Area Study[1] found lifetime and 6-month community substance abuse prevalence rates of 16.7% and 6.1%, respectively. The National Comorbidity Survey[2] found lifetime and 12-month rates of 26.6% and 11.3%, respectively. Prevalence rates for hospitalized individuals also are high and vary by specific service. The highest prevalence rates are seen among psychiatric (55.9% current, 74.0%

lifetime) and trauma (46.7% 6-month, 68.9% lifetime) inpatients.[3,4] Lower current prevalence rates (19.7%) are seen among medical-surgical inpatients.[5] Current substance abuse prevalence rates range from 17.9% to 39.6% for emergency department patients and 14.3% to 35.8% for medical outpatients.[4]

Despite the frequent occurrence of substance abuse in medical practice, physicians and other health care providers routinely fail to detect and treat it.[5-7] Barriers to the timely diagnosis and effective treatment of substance abuse include moralistic and antidisease beliefs; the extension of denial from the substance abuser to the family, workplace, and community; and negative and pessimistic attitudes, inadequate knowledge, and poorly developed practice skills among health care providers.

Medical educators have addressed the negative attitudes and knowledge and skills deficits by integrating substance abuse teaching into medical school curricula, primary care medical education, and continuing medical education.[8] Progress has occurred over the past ten years through the implementation of new or expanded medical curricula;[9] the creation of faculty development initiatives and national addiction practitioner associations;[9] the development of model curricula for physician education;[10] and the distribution of minimum knowledge and skills teaching objectives for six physician specialties.[11] Locally, the Medical and Chirurgical Faculty of Maryland created an effective substance abuse education program for primary care physicians[12] and the Governor's Drug and Alcohol Abuse Commission developed the Maryland Addiction Training Center to allow addiction trainers at all levels to exchange ideas.

At the same time that medical educators were placing increased emphasis on substance abuse education, other health care professions were addressing this important area as well. In 1988, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) funded three curriculum development projects for nursing[10] and the Department of Education through its Fund for Post-Secondary Education (FIPSE) grant program funded a national pharmacy curriculum development project directed by the University of Maryland School of Pharmacy. Also in 1988, the American Dental Association mandated all dental schools to develop formal substance abuse curricula. Finally in 1989, the Office of Substance Abuse Prevention and the National Association of Social Workers jointly published a resource guide on alcohol and other drugs for social work educators.[13]

The State of Maryland has comprehensive addictions training at all levels for physicians and other licensed health care providers. This article describes the current status of training for physicians in the state, as well as for dentists, nurses, pharmacists, psychologists, and social workers.

Physician training

Medical student education. Medical schools are currently required by the Association of American Medical Colleges to have courses in substance abuse, but the number of hours is not specified. Consequently, most medical schools nationwide dedicate less than 1% of their required curriculum hours to substance abuse education. Maryland's three medical schools historically have placed more emphasis on substance abuse training than their national peers.

University of Maryland School of Medicine. In 1972, the University of Maryland at Baltimore was awarded an Interdisciplinary Alcoholism Education Grant from NIAAA. The grant, which lasted seven years, facilitated the development of an integrated alcoholism curriculum in the school of medicine. In 1988, the curriculum was formally reviewed and reorganized into an integrated substance abuse curriculum for all students across the first three years.

First-year students receive approximately 120 hours of instruction in the introduction to clinical practice course that focuses on the doctor-patient relationship. The adverse effects that substance abuse can have on the doctor-patient relationship are examined in detail. Five 90-minute lectures on addictions are each accompanied by a faculty-led, 90-minute small group. Three of the five groups include interviews with recovering individuals (smokers, alcoholics, and drug addicts). The lectures and small group experiences are supplemented by a two-hour visit to an addiction treatment program. These 17 core hours focus primarily on attitude, general knowledge, and interviewing skills.

In addition to the required time, a one-week elective course on addictions is offered to a select group of students during the summer at the University of Utah School of Medicine. Over the past 4 years, 6 to 10 students per year have attended. For the past two years, two students have returned from the Utah course to serve as school peer substance abuse advisors as part of a new campus prevention program.

In the second year, the core substance abuse teaching (12.5 hours) takes place in the psychopathology and clinical pharmacology courses. In psychopathology, the four lecture hours are supplemented by a 90-minute small group that is attended by a recovering alcoholic involved in Alcoholics Anonymous (AA). In pharmacology, the five lecture hours

on the pharmacology of the major drugs of abuse are supplemented by a two-hour clinical correlation conference on sedative and stimulant addiction.

In the third year, the core teaching takes place during the required six-week clerkship in psychiatry. Seven lecture hours emphasize knowledge acquisition and practice skill development, supplemented by mandatory attendance at an Alcoholics or Narcotics Anonymous meeting accompanied by a recovering physician. Half of each clerkship group also spends four hours each week in a substance abuse treatment program refining their interviewing and intervention skills. In addition, all students receive additional training from the University of Maryland Medical Center's Substance Abuse Consultation Service during their clerkships in medicine, surgery, and obstetrics.

In the fourth year, electives in addiction medicine are available in a number of inpatient and ambulatory practice sites. Each year approximately six students complete a one-month elective. Students who have a special interest in addiction medicine or psychiatry are able to add to the skills and knowledge gained during the 43.5 required hours in the core curriculum.

Uniformed Services University F. Edward Hébert School of Medicine. Medical students at the Uniformed Services University of the Health Sciences (USUHS) receive a range of instruction in addictions that bridges several basic science and clinical departments. In the first year, lectures, panels, laboratories, and conferences on substance abuse are found within courses given by the departments of medicine, family practice, and medical psychology for a total of 9.5 hours of specific instruction.

In the second year, lectures, workshops, and laboratories are found within courses given by the departments of pharmacology, medicine, and psychiatry for a total of 11 hours of specific instruction. The pharmacology course covers the basic principles of drug action and drug properties in treating disease. Four hours of lecture cover substance abuse: one hour for alcohol, one for hallucinogens and marijuana, and two for other abused drugs. Within this context, there is a one-hour lecture on drug-induced disease and a two-hour workshop on drug use in special populations. Human behavior covers normal human development and psychopathology. Major psychiatric disorders are introduced with attention to the biological, psychological, and social factors involved in the diagnosis and treatment. Two hours of lecture are devoted to substance-related disorders, followed by a two-hour laboratory in which students speak with a volunteer patient undergoing treatment in a residential treatment facility.

For third-year students beginning their clinical clerkships, most didactic and treatment experience with substance-related disorders is done during the six-week rotation in psychiatry. Students participate in practical clinical work on an inpatient unit or psychiatric consultation service. They participate in a seminar on substance-related disorders and are required to attend one AA meeting. Students learn to detoxify patients with comorbid and primary addiction problems and become familiar with rehabilitation programs available for follow-up.

Fourth-year students have a wide range of choice for four-week electives, including rotations in each of the treatment clinics within the military hospital system. Experience may include intensive inpatient, residential, and outpatient treatment facilities. In addition, it is possible to develop a research topic at the Center for Training and Education in Addiction Medicine.

Johns Hopkins University School of Medicine. The Johns Hopkins University Blades Center for Clinical Practice and Research in Alcohol and Drug Dependence was established in 1986 with a threefold mission: to foster teaching on alcohol and other drug issues in the schools of medicine, hygiene and public health, and nursing; to improve the delivery of health care to patients with alcohol- and drug-related problems; and to generate research on alcohol and other drug issues. With regard to education, the center was designed to focus on improvements needed in medical education to enable physicians to intervene effectively in prevention, early identification, and treatment of patients with alcohol and other drug problems. The Center is built upon the collaborative efforts of four key departments: gynecology/obstetrics, medicine, pediatrics, and psychiatry.

Under the Center's guidance, the substance abuse curriculum for The Johns Hopkins University School of Medicine was developed to follow an integrated model for teaching medical students about alcohol and drug abuse/dependence. The basic curriculum of 10 topics includes biochemistry and pharmacology of alcohol and other drugs; etiology of alcohol/drug dependence; epidemiology of alcohol/drug dependence; natural history of alcohol/drug dependence; diagnosis of alcohol/drug dependence; alcohol/drug intoxication and withdrawal; treatment of alcohol/drug abuse and dependence; major medical and psychiatric complications of alcohol/drug dependence; and overview issues involving alcohol/drug abuse and dependence. The model is integrated throughout basic and applied science courses during years 1 and 2 and throughout the required clinical clerkships in years 3 and 4 for a total of 19 hours of training. During their third and fourth clinical years, students rotate through various

inpatient and outpatient treatment settings at the Johns Hopkins Medical Institutions and elsewhere to develop their clinical skills in diagnosing and treating patients with alcohol/drug abuse or dependence. They participate in practical clinical work on an inpatient unit or consultation service where they receive individual supervision from staff. They also participate in seminars and case conferences.

Graduate medical education (residency training)

Most residency training programs are required by the Accreditation Council on Graduate Medical Education to provide supervised training with individuals suffering from alcoholism and drug addiction. However, neither the type of training nor the number of cases or hours is specified. In response to the lack of standards, model programs have been proposed[7,14] and curriculum guidelines developed.[10,11] An integrated addictions curriculum for psychiatry residents at the University of Maryland and the addictions training program in pediatrics at Hopkins have recently received national recognition.[15-17]

Postgraduate medical education (fellowship training)

Four institutions in Maryland offer postresidency fellowship training in addiction medicine and/or psychiatry.[18] Two are clinically oriented and affiliated with psychiatry residency programs and the other two are research oriented and affiliated with the National Research Institutes (NIDA & NIAAA).

University of Maryland addiction psychiatry fellowship. Started in 1989 with a primary goal to train psychiatrists as clinician-administrators for leadership roles in substance abuse treatment programs, the one-year, full-time fellowship is organized into three blocks: 60% clinical and administration, 20% teaching, and 20% research. Another year can be added for those who want to pursue an academic career. Fellows rotate through the University of Maryland Medical Center, the Baltimore VA Medical Center, the Walter P. Carter Center, and several community-based treatment programs for their clinical training. Research training takes place either on campus or at several off-campus research centers. Since 1989, comprehensive training has been provided to four postresidency fellows and seven PGY4 psychiatry residents.

Uniformed Services University addiction medicine fellowship. Through the departments of psychiatry and preventive medicine, USUHS developed an addiction medicine fellowship program in 1993. The first fellows entered the program in July 1994. The program accepts military and commissioned corps medical officers who have completed a residency program in psychiatry, family practice, internal medicine, or preventive medicine. Two program options are available; a one-year clinical fellowship and a two-year clinical research fellowship. The clinical year includes four clinical rotations with on-site supervision, a core didactic curriculum, and research and teaching experience. USUHS provides or coordinates didactic and research experience. Consistent with the University of Maryland program, 60% of the fellow's time is spent with clinical and administrative areas, 20% is spent teaching, and 20% is spent working on a research project. An additional second year allows the fellow to enter and complete the MPH program at USUHS. There is one Navy fellow on the two-year program and one Army fellow in the one-year program.

NIDA Addiction Research Center addiction medicine fellowship. Established in 1990, this program is organized to train clinician-researchers over a two-year period. In the first year, emphasis is on the clinical care of addicted patients throughout the treatment continuum; in the second year, emphasis shifts to learning research methodology and applied clinical research. Training takes place at the Addiction Research Center, the Frances Scott Key Medical Center, and Hopkins University. The fellowship is open to physicians who have completed GY1 or residency training in any specialty.

NIAAA intramural research addiction medicine. This fellowship program was established in 1982 to provide two to three years of postresidency clinical and research training for internists, neurologists, psychiatrists, family physicians, and pediatricians who are interested in alcohol abuse and alcoholism. Training takes place at the National Institute of Health Clinical Center, which has a 10-bed inpatient clinical and research unit, an outpatient clinic, and numerous basic science laboratories. The faculty includes 20 physician and/or Ph.D. staff from a variety of disciplines.

Other licensed health care professionals

Dentists. In 1989, The American Association of Dental Schools identified the substance abuse curriculum at the University of Maryland Dental School as a potential model for use nationwide. The curriculum is integrated as special modules into two existing courses across the three years of dental education. The 19 total curriculum hours include 4 in the freshman year, 11 in the sophomore year, and 4 in the junior year. The interprofessional teaching faculty includes dentists, pharmacologists, pharmacists, physicians, psychologists, and social workers. Freshman year topics include attitudes and values, epidemiology and diagnosis, and substance abuse in dental practice. Sophomore year topics

include pharmacology, screening and assessment, intervention, and treatment. Junior year topics include special populations, self-help groups, rehabilitation, and professional impairment.

Nurses. A leader in the area of graduate nursing training in addictions, the University of Maryland School of Nursing offers a program that is emulated nationally. With support from a training grant awarded by the Public Health Service Bureau of Health Professions, Division of Nursing in the Health and Human Services Administration, the nursing school developed a 42-credit masters program in community addictions nursing that includes a doctoral degree option. Coursework covers aspects of dependence on substances and other compulsive behaviors with more emphasis given to the most common clinical problems of alcoholism, drug abuse, and food addiction, as well as associated family systems and codependence problems. In addition to didactic classroom education, students get approximately 225 hours of clinical contact in patient care environments.

Pharmacists. In 1987, the American Association of Colleges of Pharmacy published national substance abuse curricular guidelines.[19] Although the current substance abuse curriculum at the University of Maryland meets these guidelines for the bachelor of science degree, it is in a state of transition. As of 1993, the pharmacy school began admitting students only into the doctor of pharmacy program, a four-year professional program that requires 132 semester hours, of which 32 deal with substance abuse concepts. The scientific basis of addiction and legal and ethical issues regarding the prescribing and dispensing of controlled substances are addressed in the first year. In the second year, key aspects of drug abuse and addiction are integrated into the neuropharmacology and behavioral pharmacology courses. In the third year, students integrate basic and clinical science, with chemical dependency and its sequelae included in discussion groups and self-directed learning experiences. Students also are exposed to the unique aspects of addiction as a component of drug information services. In the fourth year, students are exposed to experiential learning in a variety of practice settings, including addictions treatment centers. They may opt for an addictions focus in the Office of Substance Abuse Studies (OSAS), which is a specialized research, service, and education unit that is unique among pharmacy schools nationwide. In addition to teaching the required addictions content of the core curriculum, OSAS faculty and staff provide elective courses and work study experiences in addiction pharmacy.

Clinical psychologists. Two institutions in Maryland award a doctoral degree in clinical psychology approved by the American Psychological Association (APA): the University of Maryland at College Park and the University of Maryland at Baltimore County. After obtaining the Ph.D., individuals must supplement their education with two years of clinical practice supervised by a licensed psychologist before the written licensure examination can be taken. At least one year of the required experience must occur after the doctoral degree is awarded. The degree consists of 60 semester hours in courses given in that doctoral program, at least 36 hours of which are at the doctoral level. Addictions content is not a required or elective part of the core program and no specialization or subspecialization in addiction psychology is currently available. Although not exposed to addiction content in their coursework, psychologists can obtain addictions experience during their predoctoral internship or during a postdoctoral fellowship. Examples of internships with an addictions component and a postdoctoral addictions fellowship are described below.

Both the Baltimore and Perry Point Veterans Administration medical centers offer an APA-approved predoctoral internship. They are full-time for one year and organized into four three-month rotations that occur in a variety of inpatient and outpatient clinical programs, of which substance abuse is one.

The Behavioral Pharmacology Research Unit (BPRU), a part of The Johns Hopkins University, offers a two-year postdoctoral fellowship that includes participation in ongoing studies of the unit, as well as didactic experiences available through the Hopkins system. BPRU research centers primarily on pharmacologic interventions of drug addiction.

Social workers. The School of Social Work at the University of Maryland at Baltimore is the only institution in the state that awards a master's degree in social work (MSW). The MSW satisfies the basic educational requirement for licensure as a certified social worker-clinical (LCSW-C). It must be supplemented by 3000 hours of supervised clinical practice spread over two to six years before the written licensure examination can be taken.

The typical 2-year clinical program for full-time students consists of a foundation curriculum of 30 credits in the first year and a choice of 6 advanced curricula ranging from 28 to 31 credits leading to different areas of specialization in the second year. The coursework is supplemented by a two-semester supervised field placement in both years. Addictions content is integrated into several first-year foundation courses and contained in several comprehensive elective/required addictions courses in the second year. Field placement may be in an addiction treatment setting or an em-

ployee assistance program (where alcohol and other drug problems are commonly seen). Individuals in the occupational social work specialization are required to take a three-credit course in addictions while those in other specializations like mental health or families and children can choose an addictions elective. The University of Maryland recognizes a subspecialization in addictions if the student accumulates a minimum number of credits (usually about 16).

Summary

During the past decade, there has been a markedly increased emphasis on medical training in addictions. Specific topics related to abused drugs can be found within the basic science and clinical courses taught throughout all four medical school years. Postgraduate training in many residency programs now incorporates special attention to addictions within the normal course of patient care and postresidency training programs are available.

As newly trained physicians and other health care professionals become more aware of the impact of substance abuse on health care delivery, it becomes important for senior practitioners to obtain continuing education. The knowledge base in neuroscience, psychology, and sociology are expanding at such a rate that ongoing continuing education programs are required to maintain currency in the field.

Opportunities for interaction among the health professionals are numerous. Interprofessional approaches to curricular development and implementation and clinical services provision should be exploited for maximum educational benefit. When interprofessional teams of caregivers can work together to address substance abuse problems in a structured learning environment, the synergistic possibilities are immense. Interaction among professionals, however, should not be limited to campus-based learning. Distance learning as a new technological challenge should be embraced along with a commitment to develop and provide preeminent continuing education programming in addictions.

As society becomes more aware of the dimensions of the contribution of substance abuse to mortality and morbidity, it is likely that the future standard of practice will include the expectation that patients will be routinely screened for substance abuse and that case identification will lead to appropriate referral and treatment.

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Postresidency addictions training resources

- The addiction psychiatry fellowship director at the University of Maryland is David R. McDuff, M.D., (410-328-6969).
- At the Uniformed Services University of the Health Sciences, the center director is Kenneth Hoffman, M.D., M.P.H.; the training director is Jane Sasaki, M.D.; and the clinical coordinator is Judy Karger, M.S.W., (301-295-2642).
- The director for the NIDA addiction medicine fellowship is David A. Gorelick, M.D., Ph.D., (410-550-1478).
- For the NIAAA intramural research program in addiction medicine, Gerald Brown, M.D., is the fellowship director and Theodore George, M.D., the primary point of contact (301-402-1543).

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COCAINE STREET NAMES

- base (freebase)
- big flake
- blow
- C
- candy
- coke
- crack
- death hit (with strychnine)
- dust
- flake
- freebase
- girl
- girls and boys (with heroin)
- gold dust
- happy dust
- joy powder
- lady
- liquid lady (with alcohol)
- nose candy
- nose powder
- paradise
- Persian heroin (freebase with high purity heroin)
- pier
- rock
- rock candy
- she
- sleigh ride
- snow
- speedball (with heroin)
- sugar
- toot
- white lady
- zoom

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Telling the patient the diagnosis of alcoholism or drug addiction: an internist's perspective

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Telling patients the diagnosis of addiction and motivating them to treatment is one of the greatest challenges physicians can face. It will test every skill physicians possess: interpersonal, cognitive, and physical. Before it can be attempted, however, some preparation is required.

First, physicians must honestly assess their own attitudes toward alcohol- or other drug-addicted patients. Many of us have stereotyped notions based on early training experiences in which we encountered extreme examples of chronic alcoholism that may have colored our views. Further experience hopefully will have taught us that addictive diseases exist in every level of society and that preconceptions of the typical addict are inappropriate. Physicians who sincerely want to help must look at their own attitudes and make whatever adjustments are necessary to be able to offer help in a supportive, nonjudgmental way. One way is to attend 12-step meetings such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) as an observer or with a friend in recovery.

Second, physicians must become familiar with the myriad of physical and psychological manifestations of substance abuse and the various techniques available for precise diagnosis. Although medical students today receive education and training in substance abuse, older physicians may have to acknowledge a deficiency in this area. Criteria for chemical dependency can be found in the third revised or fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*. Revised editions of standard medical textbooks now contain detailed descriptions of alcohol and drug addiction and their consequences; many continuing education courses also are available (the Physician's Rehabilitation Committee and the Addictions Committee of Med Chi sponsor a CME course each fall on related issues). A number of accurate, brief questionnaires have been developed to assist practitioners in diagnosing alcohol-

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ism. Questions can be modified to fit any kind of chemical dependency.

Internists, who are often present when alcoholics or addicts encounter adverse consequences as a direct result of their primary disease, are well positioned to offer help. Although physicians may be concerned about offending patients by confronting them about alcohol or other drug use, occasions arise during day-to-day work (e.g., illness secondary to drug use, crisis events, family requests) that signal when the appropriate time for intervention has arrived. Some patients are open to discussion during routine office interactions and this will become clear during the visit. Physicians can develop a good sense of timing for intervention, a sense of when life circumstances make a patient more willing to listen to advice. One helpful approach is to convey the diagnosis of chemical dependency with the same objectivity and compassion that would be used in giving a diagnosis of heart disease or cancer.

Physicians should be familiar with the natural history of alcoholism and drug addiction, and understand the modalities of available treatment and the prognosis with treatment. Physicians who are not going to undertake direct treatment need a working knowledge of treatment facilities and professionals available in their region and beyond, as well as the basic tenets of 12-step groups such as AA and NA and the allied groups that exist for families and friends (e.g., Alanon, Alateen). Physicians also should have available information on contacting and joining such groups. It is most helpful if recovering members of your practice are consulted. Often they will be willing to take newly diagnosed patients to the appropriate 12-step meetings. In many cases, older patients are most comfortable attending AA meetings, regardless of their primary drug of choice. Referral sources and telephone numbers should be available in the office for other patients.

A directory of the more than 800 weekly AA meetings in the Greater Baltimore area can be obtained by calling 410-433-4843. A directory of treatment providers in the Baltimore area is available by calling 410-554-8111 (fax: 410-554-8122).

It is important to remember that patients may be afraid and noncompliant and require assistance to complete the referral process. Studies have shown that patients who are escorted to treatment have a higher degree of success. Friends, family, and members of 12-step groups can assist in this process.

It is unfortunate that access to quality treatment currently is limited by the financial resources of patients and the quality of their insurance coverage. Treatment options for the indigent are currently severely limited in Maryland. These constraints make the physician's commitment to the nonjudgmental, ongoing support of chemically dependent patients critical. Any internist who has had the experience of helping patients toward a life of sobriety knows, however, that the appreciation of patients and their families makes the effort rewarding in every way. ■

THOUGHTS ON "FETAL ALCOHOL EFFECT" (FAE)

"A diagnosis that implies causation should not be applied unless the relationship can be proven. Until it is known which features in individuals prenatally exposed to alcohol are uniformly and exclusively caused by that exposure, we suggest reporting only objective descriptors unless the 'full' fetal alcohol syndrome [FAS] can be confirmed."[1]

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Helping the patient in denial: the role of the family in intervention

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ABSTRACT: *Physicians can play a critical role in influencing patients to seek appropriate treatment for alcoholism and drug dependence. These illnesses are characterized by denial, which may prevent patients from seeking treatment on their own. This article discusses the role of the family in intervening with chemically dependent patients. It is important to gain input from family members in order to make a clear diagnosis and to influence the patient to seek treatment. The family intervention model developed by Vernon Johnson is used to understand the principles for intervening with chemically dependent patients. Three basic tasks for physicians treating chemically dependent patients are reviewed.*

Every day, thousands of alcoholic and drug-dependent persons seek medical treatment for ailments that may be directly or indirectly related to their chemical dependency. Physicians often have no difficulty making the diagnosis of addictive disease, but influencing the patient to seek treatment proves to be a frustrating and unsuccessful endeavor. Even the most knowledgeable physician may be no match for the armor of denial that protects addicted patients from the reality of their disease. It is at this point that family involvement becomes crucial. By becoming familiar with the family intervention model developed by Vernon Johnson,[1-3] physicians may use the family as the most powerful tool to intervene successfully with the chemically dependent patient. This article discusses chemical dependency, the family system, and the use of family intervention to influence the addicted patient to seek appropriate treatment. Three basic tasks for physician intervention are outlined.

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Disease

Chemical dependence is a primary, chronic, progressive, and potentially fatal disease.[4,5] To intervene effectively with addicted patients, physicians must understand the basic tenets of the disease model. Johnson and others[6] have described the following characteristics.

Chemical dependence is a primary illness. The addiction needs to be treated first before any other problem (e.g., financial, marital, psychological) can be successfully managed. Although many other serious problems may need to be addressed, it is unlikely that any will improve until the alcoholism or drug dependence is identified and treated.

Chemical dependence is chronic. Chemical dependence cannot be cured. It can be arrested and successfully treated, but not cured, which is why it is essential that alcohol- and drug-dependent persons abstain from all mood-altering chemicals. Suggesting a return to controlled drinking or drug use at some point in the future will trigger a relapse.

Chemical dependence is progressive. Alcohol or other drug dependence worsens the longer it remains untreated. Over time, the problems caused by alcohol and other drug use increase in number and severity.

Chemical dependence is fatal. Alcohol or other drug dependence is fatal if untreated. Traffic accidents, suicide, other forms of violence, and medical complications caused by chemical dependence are among the ways addicts die.

Chemical dependence is treatable. Drug-dependent persons who follow through with treatment can achieve stability in the process of recovery. Statistics on successful recovery run as high as 60% to 80% in employed alcoholics whose social and financial supports (i.e., family, job, health insurance) remain intact.

Denial

One of the most difficult aspects of treatment for alcoholism or other drug dependence is overcoming denial. Denial is a psychological process that keeps chemically dependent people from recognizing that substance use is the cause of their problems.[5] They commonly believe that they do not have a problem with alcohol or other drugs, even in the face of overwhelming evidence to the contrary. Asserting itself in the early stages of the disease, denial remains the most constant psychological symptom throughout the life of the disease. Concurrent with the progression of the addiction, there is a progressive inability on the part of addicted people to recognize the reality and severity of the symptoms. Just as they are victimized by the physical disease, so they are victimized by a set of psychological defenses and behaviors that allow them to distort and deny their reality. Addicts deny, rationalize, externalize, and minimize to explain away the problems created by their drinking or drug taking. These secondary defenses maintain the major defense mechanism—denial—and it is denial that is the target of all successful treatment. Only when denial is broken and addicts come face to face with the reality will they be able to recover.

A major obstacle to overcoming denial is misunderstanding of addictive disease. The moral model breeds denial by equating chemical dependence with moral weakness and unacceptable behavior.[6-8] For addicts and their families, denial is a defense against stigmatization, the inability of the addict to accept the reality of the moral model that says "I am a bad person." Families unable to escape moral model thinking and not wanting to experience the stigma for themselves or their loved ones, may avoid seeking help outside the family system. As a result, their lack of knowledge is perpetuated and prompts them to use enabling to control the dysfunction within their households. They may waste years in denial and moral model thinking until an outside force intervenes, at which time the disease may be well advanced. Physicians well versed in addiction may intervene much earlier in the disease process by using the family to break the denial, thus making the alcoholic or addict more amenable to treatment. The greatest tool at the physician's disposal is family education regarding the disease process.

The family system

Chemical dependence is a family disease. It may start with one person, but eventually every member of the family becomes involved in the disease process. Life in an addicted family is a chaotic, emotionally painful experience for all its members. To protect themselves against the painful feelings they are experiencing (anger, fear, hope, guilt, shame, loneliness), family members develop defenses and exhibit pathologies in the form of enabling and codependency that directly parallel the course of addiction in the alcoholic or addict.

Enabling includes any behavior that prevents addicts from experiencing the consequences of their alcohol or drug use. Families enable because of a misguided sense of wanting to protect the user; in fact, enabling only permits the disease process to continue. By attempting to control their loved one's drinking or drugging, by manipulating the environment to help the addict avoid the consequences of use, by putting up a good front to the public, family members

participate in their own form of denial and unwittingly dance to the rhythm created by the disease process. Only when denial is broken (via education about the disease) will family members see how enabling allows the disease process to continue and therefore prevents the addict from self-diagnosis. By educating the family, physicians can provide an alternative to moral model thinking and offer new behavioral tools for living and interacting with the chemically dependent member. When family members learn to change their behavior, they spur a crisis in the addicted person that increases amenability to treatment.

Intervention

Vernon Johnson, an Episcopal minister, developed the concept of intervention as a result of a research study conducted in his church community to discover why alcoholics seek help. One conclusion was that the chief motivating factor in the decision to seek treatment is a buildup of crises in several areas of the addict's life: "hitting bottom" eventually causes the alcoholic to seek help. Wondering why families had to wait for the person to "hit bottom," Johnson suggested raising the bottom to meet the alcoholic's present state.

An intervention is a gathering of family members and friends to present the addict or alcoholic with facts about his/her behavior. The group may include the employer, the physician, and a person retained specifically to conduct the intervention. The group is trained by the counselor during two or three sessions before the intervention meeting. Members are educated about enabling and other unhealthy behaviors, introduced to their support group/recovery programs, and taught specific methods for successful intervention. During the intervention, they calmly present facts about the addicted person's behavior, its affect on those he or she cares for, and in some cases the consequences if the behavior continues. Family members take turns stating specific concerns and expressing the desire that the individual seek immediate treatment. A successful intervention renders the alcoholic or addict unable to maintain denial and leaves no real choice but constructive action. The treatment center usually has been advised of the intervention and initial admission information already has been provided in the hope that treatment will begin on the day of intervention.

If the addict refuses treatment, significant consequences usually are ready to go into effect. In general, family and friends withdraw their support (e.g., financial, emotional) until the addict seeks help. These steps are not taken to punish the addict, but to help the family and friends protect themselves and to spur the addict to treatment.

Intervention goals

The primary goal of an intervention is to motivate the person to seek immediate treatment. Even if there is little hope that the person will go into treatment immediately, some secondary goals may be achieved:

- The enabling system is destroyed, making it more likely that the person will seek treatment in the future.
- Family and friends receive basic alcohol and other drug education. Moral model thinking is replaced with knowledge of the disease.
- Participants become aware of local treatment resources. When the addict reaches out for help in the future, the family will be able to act faster and from a better informed position.
- The conspiracy of silence is broken. Family members begin talking to each other openly about the problem.
- The family is exposed to meetings of Alcoholics Anonymous, Alanon, Narcotics Anonymous, Naranon, and other self-help groups.
- The family may suggest a contingency plan that allows the person to accept outpatient treatment. The family agrees to delay implementing consequences as long as the addict follows through and does not relapse. Under the contingency plan, if relapse occurs, the addict agrees to enter inpatient treatment immediately.

Chemical dependence is a progressive disease that worsens over time. The earlier the intervention, the less destruction to the addict's or alcoholic's health and family. The sooner the physician intervenes, the better the chances for the addict's permanent recovery. Intervention, however, is a process, not an event. It often begins with the physician's decision to educate the family in addition to (or in spite of) the addict.

Physician tasks

Make the diagnosis. It may be possible to make the diagnosis of alcoholism or drug dependence from the patient's history, physical and/or laboratory results, and other information already available to the physician. In many cases, however, input from family members may be needed to understand the seriousness of the problem.[8] Since a large component of the illness is denial, patients may be unwilling or unable to describe fully the symptoms they are experiencing. Family members, on the other hand, may be only too

willing to inform the physician of the difficulties they experience because of the patient's drinking or drug use. In addition, family members may be able to provide information that is unavailable to the patient because of memory blackouts (a common symptom of alcoholism). It is useful for the physician to first tell the patient that a family contact would be helpful, and then to ask for permission.[9] Reluctance or defensiveness by the patient may confirm the diagnosis.

In addition to providing collateral information, a screening instrument such as the CAGE,[10] Brief Michigan Alcoholism Screening Test,[11] and the Alcohol Use Disorders Identification Test[12] can facilitate the diagnostic process. Questions are worded to minimize the patient's defensiveness. Each of the instruments also can be administered to family members and any disagreement with the patient's answers can be discussed.

Tell the patient

Many physicians find it difficult to communicate the diagnosis of alcoholism or drug dependence to their patients. Many stigmatizing aspects of the diagnosis may be unpleasant to discuss. Patients are usually in denial and may become defensive and angry, perceiving the diagnosis as offensive or insulting. Physicians may be concerned about losing the patient. Nevertheless, the diagnosis should be communicated to the patient in an objective, nonjudgmental way. It is not a pronouncement of moral quality or a statement about character. It is a diagnosis of an illness and it is essential that patients be told the information. In fact, a physician's telling the information may be the single most important factor that influences a patient to seek treatment.[13] Patients may be able to deny a problem when friends and family members tell them, but are unlikely to do so when a physician provides the information in a factual way.

Refer to treatment

The level of treatment needed (inpatient, residential, intensive outpatient, regular outpatient) is determined by the seriousness of the problem. Physicians who are not comfortable making the distinction can refer to an addiction counselor or an addiction treatment program. Physicians may also recommend participation in self-help groups such as Alcoholics Anonymous and Narcotics Anonymous. Whenever possible, it is helpful if the physician facilitates contact with the treatment program by calling and making the appointment with the patient present.

Patient confidentiality

The most difficult aspect of engaging the family when treating chemically dependent patients is the issue of confidentiality. When patients are adamant about maintaining absolute confidentiality and not communicating any information to family members, physicians can do little to engage the family in treatment. Many times, however, patients will allow family members (in particular, spouses) to discuss general health issues, which should be done with the express permission of the patient and may require a signed release. With patients seriously ill because of their chemical dependence who refuse any treatment or involvement of their family, the physician may chose referral to another physician. By refusing to treat the patient further, the physician may put another dent in the patient's armor of denial.

Treating family members

Physicians often become aware of one person's chemical dependence because they treat another member of the family. In such cases, the basic tasks for the physician remain the same.

- ***Make the diagnosis.*** The diagnosis of chemical dependence is made more easily from information provided by a family member. The information usually is more accurate and reliable and may include incidents of which the chemically dependent person is unaware.
- ***Tell the patient.*** Physicians can educate family members regarding the diseases of alcoholism and drug dependence, explain the symptoms described, and provide information about treatment and recovery.
- ***Refer to treatment.*** Family members can be referred to appropriate treatment, such as an addiction counselor; a program that specializes in family intervention; or Alanon, Alcoholics Anonymous, Narcotics Anonymous, or Naranon meetings. In such cases, there is no issue of patient confidentiality because the referred patient is the family member.

Case history

A 53-year-old man presented to an internist for a physical examination. When asked about drinking or drug use, he admitted to only one to two drinks per day. Laboratory results, however, showed a profile consistent with heavy alcohol use and the beginning stages of liver damage. During the next meeting, the internist presented the information to the patient and pressed him for more detailed information about his drinking. The patient increased his estimate of

number of drinks per day, but denied any serious problem. Expressing concern about the laboratory results and the possible consequences on the patient's health, the physician strongly recommended a trial of abstinence. After failing the trial, the patient reluctantly agreed to see an addiction specialist and did so after some delay. The specialist asked the patient to come in with his wife for additional information. The written report to the internist clearly indicated the diagnosis of alcoholism, which was causing serious problems with the patient's health, marriage, and relationship with his adult children. A treatment plan was designed in consultation with the addiction specialist and input from family members. The patient decided to comply because of the insistence of the family members.

Case history

During the course of marital counseling, it became clear to the treating psychiatrist that the wife's drinking was having a major impact on the relationship. The psychiatrist recommended addiction treatment. When the wife refused, the psychiatrist decided to terminate marital counseling until she accepted appropriate treatment and was in recovery. Several months later, still wanting to save her marriage, she accepted treatment and entered a residential program.

Case history

A patient admitted to Shock Trauma due to an alcohol-related traffic accident was transferred to a step-down unit after four days. During the hospitalization, the attending physician requested an alcohol/drug consultation, which showed that the patient had a serious problem with alcohol and drug abuse. The physician communicated the diagnosis to the patient while he was still in the hospital and referred him to treatment upon discharge.

Summary

Although substance abuse is one of the most commonly seen problems in medical practice, there are still many barriers to its timely diagnosis and effective treatment.[14,15] These include the belief that substance abuse is caused by a moral defect or deficiency of willpower; the extension of denial from the substance abuser to the family, workplace, and the community; and negative attitudes, inadequate knowledge, and undeveloped practice skills among health care practitioners. Because physicians and other providers have multiple opportunities in a typical practice year to intervene with substance abusers, it is critical that these barriers are removed. This article recommends greater use of the disease model of addiction, screening instruments, collateral contacts with family members, and formal interventions to improve diagnosis and treatment.

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■

Health habits of recovering alcoholics

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ABSTRACT: *Heavy drinkers and alcoholics are known to have generally poor health habits in terms of cigarette smoking, seat belt use, diet, and preventive health practices. Little is known, however, about health habits of recovering alcoholics. We analyzed national survey data to describe the health habits of recovering alcoholics compared with heavy drinkers (four or more drinks per day). Recovering alcoholics had a significantly elevated odds of using seat belts regularly and reporting preventive health practices that are known to reduce the risk of cardiovascular disease. In addition, recovering alcoholics were at significantly decreased odds of being cigarette smokers. Although the cross-sectional data have limitations, they indicate there may be more health benefits in recovery from alcoholism than abstinence alone.*

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Background

Personal habits and lifestyle practices are known to influence physical health and longevity.[1-3] An estimated 15.3 million U.S. adults abuse alcohol or are alcohol dependent,[4] and studies have shown that heavy alcohol use is highly correlated with poor health habits. Heavy drinkers are two to three times more likely than nondrinkers to be cigarette smokers.[5] The prevalence of cigarette smoking among alcoholics has been reported to be as high as 80% to 95%.[6-10] Heavy drinkers are less aware of the connection between diet and health and are more likely to report unhealthy dietary behaviors.[11] Studies also have shown that heavy drinkers, particularly those who drink and drive, are less likely to use seat belts.[12,13] Such unhealthy behaviors, combined with the toxic effects of

Table 1. Sociodemographic characteristics of recovering alcoholics and heavy drinkers—United States, 1990

	Recovering alcoholics	Heavy drinkers
Sample size	377	678
Population size	1,533,344	3,086,034
Characteristic	% (SE)	% (SE)
Sex		
male	73.7 (2.5)**	89.2 (1.3)
female	26.3 (2.5)**	10.8 (1.3)
Age		
18-44	56.1 (3.0)	61.8 (2.2)
45-64	33.8 (2.9)	27.7 (2.1)
≥ 65	10.1 (1.6)	10.5 (1.3)
Race		
white	92.0 (1.8)	87.4 (1.6)
black	5.7 (1.4)*	10.6 (1.5)
other	2.3 (1.2)	2.0 (0.8)
Education		
< 12 years	25.2 (2.7)	26.7 (2.2)
high school	35.4 (2.8)*	43.2 (2.4)
> 12 years	39.4 (2.7)**	30.1 (2.2)
Household income		
< $20,000	37.2 (2.6)	36.0 (2.0)
≥ $20,000	62.8 (2.6)	64.0 (2.0)
Marital status		
married	61.0 (2.6)	56.8 (2.3)
previously married	24.3 (2.1)*	18.3 (1.5)
never married	14.8 (1.9)*	24.9 (2.1)

* $p < 0.05$, t-test
** $p < 0.01$, t-test

Source: CDC, NCHS, NHIS-Health Promotion and Disease Prevention, 1990.

heavy alcohol consumption, place heavy drinkers and alcoholics at increased risk for a variety of acute and chronic medical conditions.[14,15]

Recovering alcoholics represent a unique group of individuals who have achieved periods of abstinence from alcohol and thus successfully modified the risk behavior of hazardous drinking. There is limited knowledge of health habits and practices of recovering alcoholics. A small prospective study based on a convenience sample of recovering alcoholics recruited from Alcoholics Anonymous (AA) in Baltimore, Maryland, showed that cigarette smoking rates declined with extended abstinence from alcohol.[16] To our knowledge, no studies have described the health habits of recovering alcoholics based on a probability sample of the U.S. household population. In the current study, we used national survey data to describe the health habits of recovering alcoholics and compare these health habits with those of heavy drinkers.

Data and methods

Data from the 1990 National Health Interview Survey of Health Promotion and Disease Prevention (NHIS-HPDP) were analyzed. The NHIS is an ongoing, nationwide household survey conducted by the National Center for Health Statistics (NCHS). Basic health and demographic data are gathered on a probability sample of the civilian noninstitutionalized household population in the United States. In 1990, the HPDP was administered as a special health topic and contained detailed questions on health practices, including alcohol consumption, cigarette smoking, nutrition, injury control, and preventive health care. Information was collected through personal interview with a randomly selected household adult aged 18 or older. The overall response rate (incorporating nonresponse to the NHIS) was 83.4%; the sample size was 41,104 adults. A more detailed description of the NHIS-HPDP and findings are available in another report.[17]

For our analysis, two study groups were assembled on the basis of responses to alcohol use questions. Those who selected the *recovering alcoholic* response category as the main reason for not drinking in the past year constituted the recovering alcoholic group. Respondents who, based on two-week recall, reported drinking on average four or more drinks per day were classified as heavy drinkers.

Sociodemographic characteristics and health habits for both groups were estimated and tests of statistical significance were performed using a t-test. Logistic regression models were constructed to assess the independent effect of recovery status on selected health practices and habits. All data were weighted to produce national estimates, and analy-

ses were done using the SUDAAN software, which adjusts for the complex survey design.[18]

Results

Of the 12, 812 interviewed respondents who reported not drinking alcohol in the year prior to the NHIS interview, 377 gave *a recovering alcoholic* as the main reason for not drinking. This represents an estimated 1.5 million recovering alcoholics, or 2.8% of the nondrinking U.S. adult population. Among respondents who reported alcohol use, 678 adults reported drinking, on average, four or more drinks per day, representing 3.1 million U.S. adults.

Sociodemographic characteristics of recovering alcoholics and heavy drinkers are presented in **Table 1**. Men made up the majority of both groups, although the proportion of men in the recovery group (73.7%) was significantly smaller than in the heavy drinking group (89.2%). The difference in mean age for those recovering (44 years) and for heavy drinkers (42 years) was significant at $p < 0.05$. Ninety-two percent of the recovering alcoholics and 87.4% of the heavy drinkers were white. Significantly fewer of those in recovery were black (5.7%) compared with the heavy drinkers (10.6%). Educational differences were found between the two groups. A significantly greater proportion of the recovery group (39.4%) had exceeded a high school education compared with the heavy drinkers (30.1%). More recovering alcoholics (24.3%) were either divorced, separated, or widowed compared with heavy drinkers (18.3%), although the proportion of heavy drinkers who were never married (24.9%) was higher than in the recovering group (14.8%).

Health habits of recovering alcoholics and heavy drinkers are presented in **Table 2**. With the exception of eating breakfast and exercising, significantly more of the recovering alcoholics engaged in behaviors and practices consistent with good health compared with heavy drinkers. Fewer smoked cigarettes (50.5% vs. 62.2%) and a greater proportion reported wearing a seat belt regularly (57.4% vs. 43.8%), having a usual source of medical care (79.7% vs. 63.6%), having had their blood pressure checked in the past year (86.7% vs. 75.6%), having ever had their blood cholesterol checked (56.9% vs 39.6%), and having made lasting changes to their diet to reduce blood cholesterol (35.6% vs. 23.7%).

Odds ratios for these health habits and practices, adjusted for the sociodemographic covariates that have a potential

Table 2. Health habits of recovering alcoholics and heavy drinkers—United States, 1990

Characteristic	Recovering alcoholics % (SE)	Heavy drinkers % (SE)
Eat breakfast		
almost every day	44.1 (2.9)	39.3 (2.2)
sometimes	19.9 (2.3)	22.3 (2.0)
rarely/never	36.0 (2.8)	38.5 (2.0)
Exercise or play sports regularly		
yes	37.9 (2.8)	37.0 (2.2)
no	62.1 (2.8)	63.0 (2.2)
Cigarette smoking		
current smoker	50.5 (3.0)*	62.2 (2.3)
former smoker	35.1 (2.7)*	23.1 (2.0)
never smoker	14.4 (2.0)	14.7 (1.6)
Seat belt use		
all/most of the time	57.4 (3.0)*	43.8 (2.3)
sometimes	26.5 (2.6)	27.6 (2.1)
never	16.1 (2.2)	28.6 (2.2)
Usual source of medical care		
yes	79.7 (2.3)*	63.6 (2.2)
no	20.3 (2.3)*	36.4 (2.2)
Blood pressure checked (past year)		
yes	86.7 (2.0)*	75.6 (2.0)
no	13.3 (2.0)*	24.4 (2.0)
Blood cholesterol checked (ever)		
yes	56.9 (2.9)*	39.6 (2.2)
no	43.1 (2.9)*	60.4 (2.2)
Modified diet to reduce cholesterol		
yes	35.6 (2.9)*	23.7 (2.2)
no	64.4 (2.9)*	76.3 (2.4)

* $p < 0.01$, t-test

Source: CDC, NCHS, NHIS-Health Promotion and Disease Prevention, 1990.

Table 3. Adjusted odds ratios* and 95% confidence intervals for selected health habits: recovering alcoholics compared with heavy drinkers—United States, 1990

Health habit	Odds ratio*	95% Confidence interval
▪ Has usual source of care	1.93	1.33 - 2.81
▪ BP checked past year	1.82	1.18 - 2.80
▪ Cholesterol checked (ever)	1.75	1.28 - 2.40
▪ Change diet to lower cholesterol	1.55	1.11 - 2.17
▪ Wears seat belt	1.42	1.02 - 1.98
▪ Eats breakfast	1.13	0.82 - 1.54
▪ Exercises	1.07	0.78 - 1.47
▪ Smokes cigarettes	0.61	0.43 - 0.85

* Adjusted for sex, age, race, education, income, and marital status.

Source: CDC, NCHS, NHIS-Health Promotion and Disease Prevention, 1990.

effect on their likelihood, are presented in **Table 3**. With the heavy drinkers as a referent group, the recovering alcoholics had a statistically elevated odds of engaging in all healthy practices with the exception of eating breakfast daily, exercising routinely, and smoking cigarettes. The adjusted odds ratio for cigarette smoking significantly decreased for the recovering alcoholics compared with heavy drinkers.

Discussion

This study is the first to present data on recovering alcoholics based on a national survey. The large sample size of the 1990 National Health Interview Survey of Health Promotion and Disease Prevention provided a unique opportunity to collect and analyze data from a relatively small and difficult population to study, i.e., recovering alcoholics with one or more years of abstinence. Most existing research on alcoholics in recovery was based on convenience samples drawn from treatment centers; the population-based design of the NHIS avoids bias arising from such selection factors.

In the current study, the prevalence of cigarette smoking was lower among recovering alcoholics than among heavy drinkers. Because both groups had equal proportions of never smokers, the main factor contributing to the lower smoking prevalence among recovering alcoholics is successful smoking cessation. A prospective study of recovering alcoholics recruited from AA found a smoking cessation rate of 58% for men and 48% for women over a 4-year follow-up period.[16] Studies show that alcoholics entering treatment also are interested in receiving smoking cessation treatment.[19,20]

Consistent use of seat belts was reported more often among those recovering than among the heavy drinkers. This behavior, in conjunction with abstaining from alcohol, is known to reduce the risk of accidental injury or fatality from a motor vehicle crash. Seat belt use among those recovering, however, is still not as high as among the general population. Over two thirds of all adults surveyed in the 1990 NHIS-HPDP wore seat belts all or most of the time.[17]

Although no differences were found in the proportion of recovering alcoholics and heavy drinkers who exercised regularly, more of the recovering alcoholics reported preventive health practices that are known to reduce the risk of cardiovascular disease. Compared with heavy drinkers, the recovering alcoholics were more likely to report having a usual source of medical care and to have been screened for high blood pressure and high blood cholesterol. We cannot determine if these differences are due to differences in access to care between the two groups, or if those in the recovering group were more likely to have a usual source of medical care because of ongoing treatment for alcoholism.

Three major limitations of our study are the validity of self-reported information; the acceptability of heavy drinkers as a comparison group; and the nature of cross-sectional data.

Recovering alcoholic is a volunteered response and therefore is subject to the potential biases of such responses. Individuals not wishing to disclose prior alcoholism would be misclassified and exclusion of these respondents could bias the findings. Although research has shown that heavier drinkers and problem drinkers underestimate their alcohol intake,[21] the validity of an alcoholic's reporting recovery from alcoholism has not been tested.

A meaningful comparison group for testing whether the health habits of alcoholics in recovery are different from those still drinking would be practicing alcoholics. The NHIS-HPDP did not include questions necessary to identify alcohol dependence. Prior research based on the 1988 NHIS, however, found the positive predictive value of an average ethanol intake of 2 or more ounces (4 or more drinks) per day as a consumption indicator for alcohol dependence was 42% for men and 40% for women.[22]

The current research was based entirely on cross-sectional survey data. Therefore, no exploration of the temporal relationship of recovery from alcoholism and engaging in

healthier behaviors was possible. Two possible theories emerge based on the findings from this study. First, individuals with healthy habits and practices may be more likely to begin and maintain a program of recovery from alcoholism. Second, recovering alcoholics may come to value their health more and take health enhancing action as an extension of this belief. The findings of DeSoto and colleagues[16] regarding smoking cessation are more consistent with the latter. Further longitudinal or prospective studies of alcoholics in recovery are needed to better define factors involved in adopting and maintaining habits consistent with good health.

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Alcohol-related dementia (ARD) may be underdiagnosed in the elderly. Canadian investigators who examined the distribution of dementias in 130 cognitively impaired, long-term care residents (average age, 81 ± 9 years) found that 35% had dementia of the Alzheimer type, 19% had vascular dementia, 24% had ARD, and 22% had miscellaneous dementias (e.g., Parkinsonian dementia, brain trauma or tumor, depressive pseudodementia). Of those with ARD, however, only 25% had been accurately diagnosed.

The diagnosis of ARD was based on extensive review of medical history to assess prolonged (more than five years just before admission) and excessive alcohol use (averaging more than 6 oz/day); lack of progression in cognitive decline for at least the first year after admission; and exclusion of other causes of dementia. Investigators also found that members of the study population with ARD were on average 10 years younger, had almost twice the average length of hospitalization, and had milder cognitive impairment than other subjects. The authors conclude that patients with ARD require different types of support than patients with other forms of dementia.[1]

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Medical and Chirurgical Faculty of Maryland

Physician Rehabilitation Committee

Changes in the application for medical license renewal

Department of Health and Mental Hygiene
Martin P. Wasserman, M.D., J.D., Secretary
Board of Physician Quality Assurance
J. Michael Compton, Executive Director
Maryland Health Care Access and Cost Commission
John Colmers, Executive Director
Maryland Health Resources Planning Commission
James R. Stanton, Executive Director

In an ongoing effort to improve access to quality and cost-effective medical care for Maryland residents, Martin P. Wasserman, M.D., J.D., Secretary of Health, leads the Department of Health and Mental Hygiene (DHMH) in requesting the cooperation of all physicians licensed in Maryland to provide information about their medical practice. Collection of the necessary data will begin during the 1995-1996 medical license renewal cycle. Therefore, the licensing packet that will be mailed in July is now in three sections:

- the License Renewal Form -Parts A and B;
- the Supplemental Renewal Form; and
- the Health Care Provider Data Sheet.

Every data element on the forms has been reviewed by the Board of Physician Quality Assurance (BPQA) to ensure that only necessary information is requested. In addition, every effort will be made to ensure that no duplication of data collection, beyond basic identifiers, occurs within DHMH (i.e., multiple surveys asking for the same data from DHMH programs) and that, in future years, each physician will only update information already supplied.

New data elements and use of collected data

A cooperative effort is being undertaken by the BPQA, the Health Resources Planning Commission, and the Health Care Access and Cost Commission to ascertain better the supply and distribution of physicians and other health professionals in Maryland. The data from this ongoing effort will be used for a wide variety of public health projects that can benefit the citizens of Maryland, the health department, and individual practitioners. The new data elements and examples of how the collected information will be used to meet federal and state statutory responsibilities are presented in **Table 1**. All public release of nonpublic data will be in aggregate and is not intended to restrict or regulate the training, location, reimbursement, or medical practice patterns of any individual physician.

Public health: cost-effective health analysis

The DHMH works with health care providers to make the existing delivery system more responsive to the health care needs of all Maryland citizens. The task would be daunting even if unlimited financial resources were available. Because health care inflation continues to outpace economic expansion, however, in real dollars both federal and state funding is decreasing, while health care needs are not yet fully met. Therefore, it is imperative that state agencies develop or expand the tools at their disposal to meet their mandated responsibilities by more effectively allocating limited funding. This can be accomplished through improved health data that includes better estimates of both the demand for health care and the supply of resources (including practitioners).

Demand: need for services

The DHMH currently uses a variety of tools to estimate demand for services. One method for estimating disease incidence is to compare national formulas for disease occurrence within a given population to Maryland's population demographics. Another analysis (which can be performed at or below the county level) uses hospital discharge data to develop disease-specific health indices. A third tool determines a state average for a variety of health indicators and a ranking of each jurisdiction or community against that mean, allowing the state's public health officials to identify competing health priorities and allocate resources accordingly. These and other health indicator tools are used not only to identify the health needs of Maryland's citizens, but are also the basis for evaluating specific interventions to determine cost-effectiveness.

Supply: why physician data are necessary

Estimating demand, however, is only half the equation. Effective health promotion, prevention, and analyses also must take into account the current amount and distribution of resources—facilities, services, technologies, and *providers*. With regard to physician and other health personnel resources, this information is at present only partially available. This situation greatly hinders the effectiveness of the health care efforts of DHMH to encourage healthy behaviors. For example, funding spent to promote proper

Table 1 Purposes, Data Elements, and Legal References

Purposes	*Data Elements on Renewal Forms*	*Legal References*
To obtain data BPQA is required by law to collect To catalog the current inventory and availability of active practitioners by specialty in order to geographically map, at the street address level, the distribution of all service sites including those outside the State	• office/practice locations • jurisdiction • at each site, average number of hours per week available for patient care • area of concentration • total number of locations • if all offices located outside Maryland, treat Maryland residents	Health Occupations Article, §14-316(d), and Health-General Article, §19-101 et seq., Annotated Code of Maryland
To propose areas for designation as federal Health Professional Shortage Areas (HPSAs) for selected specialties based on geographic or special population (poverty population) criteria which can lead to the placement of National Health Service Corp Physicians To assist with Medically Underserved Area (MUA) primary care designations, necessary for establishing Federally-Qualified Community Health Centers that treat many uninsured and Medicaid-eligible Marylanders To collect general demographic information that can be used to address specific issues with respect to physician shortages and access to care To identify critical areas where the loss of a full or part time physician could restrict access to treatment	• office/practice locations • Medicaid Provider Number † • currently retired • year of birth • at each site, average number of hours per week available for patient care • area of concentration • accepting new Medicaid patients • ending practice in next 2 years • race •gender	Section 332 of the Public Health Service Act Section 330(b)(6) of the Public Health Service Act Health Occupations Article, §14-207, Education Article, §18-804.1, and Health-General Article, §19-101 et seq., Annotated Code of Maryland
To identify specialty physician shortages whose scarcity can jeopardize the availability of needed health services To analyze where and when current practitioners were trained in order to distribute State and federal funds from both the Loan Assistance Repayment Program, which aids new practitioners in repaying educational loans, and the Health Manpower Shortage Incentive Grant Program, which provides funds to higher education institutions training these scarce professionals	• office/ practice locations • medical school of graduation • Medicaid Provider Number † • year of graduation • gender • at each site, average number of hours per week available for patient care • area of concentration • medical school location • accepting new Medicaid patients • year of birth • race	Health Occupations Article, §14-207, Education Article, §18-804.1, and Health-General Article, §19-101 et seq. , Annotated Code of Maryland
To identify existing and emerging trends with regard to practice and to ascertain the current utilization of mid-level providers	• practice setting • role • area of concentration • practice type • private/public affiliation • physician assistant, nurse practitioner, or nurse midwife part of practice	Health Occupations Article, §14-207, Education Article, §18-804.1, and Health-General Article, §19-101 et seq., Annotated Code of Maryland
To link health care claim encounter data with the physician and practice providing the services in order to report service utilization and costs by geographic region and health care specialty to the General Assembly. ‡	• organization name • office/practice locations • office phone number • jurisdiction • area of concentration • practice setting • practice type • role • private/public affiliation • Medicare UPIN • Medicaid Provider Number † • Tax Identification Number	Health Occupations Article, §1-210, Health-General Article, §19-1507(f), and §19-1509(e), Annotated Code of Maryland
To facilitate the investigation of complaints against licensed physicians	• Drug Enforcement Agency Number • Maryland Controlled Dangerous Substance Number • states other than Maryland in which an active medical license is held	Health Occupations Article, §14-401, Annotated Code of Maryland

† As of July 1, 1995, all providers rendering service to Medical Assistance recipients will be assigned a nine-digit provider number. The first five digits are the current number, the sixth will correspond to the provider type, the seventh will be a random computer-generated algorithm, and the eighth and ninth numbers will designate the location where the service is rendered.

‡ Medicare and Medicaid Provider Numbers are required until assignment of a National Provider Identifier. Currently, the U.S. Health Care Financing Administration has tentative plans for state licensing boards to assign this identifier.

prenatal care in order to reduce the incidence of infant mortality and low birthweight newborns can have only limited success when an expectant mother does not have geographic access to an obstetrician, regardless of the woman's ability to pay for care.

Principal benefits

Once collected and analyzed, aggregate and nonconfidential data will be treated as public information and will be available on request by private parties. In fact, every effort will be made to share the knowledge with the medical community and all interested parties. Some of the potential benefits include:

- An improved opportunity for physicians to identify and refer patients to colleagues outside their own specialties whose offices are conveniently located near their patients' homes or workplaces.
- An opportunity for physicians to strengthen ties with other physicians in their own specialties statewide.
- An opportunity for physicians entering, relocating, or expanding their practice to identify areas that need practitioners in their specialties. For example, reports containing resource distribution maps are expected to be publicly available. They can be used in conjunction with "user defined market areas" that provide socioeconomic and demographic characteristics based on site radius (available to public and private users for nominal fees from the Maryland Office of Planning) to facilitate business decisions.
- An opportunity for the state to avail itself of all outside resources (federal government, public foundations, and private grants); to maximize the effective use of available state resources; to implement more timely, cost-efficient strategies that address Maryland's future health needs; and to promote increased access to quality, cost-efficient health care services for all Marylanders.

Conclusion

The licensed physicians in Maryland represent the backbone of the state's reputation for quality health care and innovative health policy. Now, as the twenty-first century draws near, maintaining this position as a leader in the delivery of health services may well hinge on the state's ability to collect accurate data, both demand- and supply-side. As a consequence, physicians are requested to participate in a new era of cooperation, one in which the DHMH can be viewed as a greater source of health information and a stronger partner in the statewide provision of accessible, quality, and cost-effective medical care.

Prepared by Kelly Heilman, MBA, Division of Health Systems Planning, Maryland Health Resources Planning Commission.

Acknowledgement

The authors gratefully acknowledge the assistance of Edna Amador (BPQA), Margaret T. Anzalone (BPQA), Linda Bartnyska (MHCCAC), Dick Brandt (MHCCAC), Mark Higby (BPQA), Kery Hummel (MHRPC), Patricia Keimig (MHRPC), Larry Monroe (MHRPC), Virginia Seyler (DHMH), Ben Steffen (MHCCAC), Jeanette Washington (MHRPC), and Carolyn B. Wescott (BPQA), who aided in the verification and editing of this document and in the development of the data collection instrument. ■

Requests for additional information can be addressed to Kelly Heilman or Jeanette Washington, Maryland Health Resources Planning Commission, 4201 Patterson Avenue, Baltimore, MD 21215. Telephone 410-764-3255; FAX 410-358-1311.

In Memoriam



Marion Carlyle Crenshaw, Jr., M.D., a member of the editorial board of the *Maryland Medical Journal,* and professor and chairperson of the department of obstetrics and gynecology at the University of Maryland School of Medicine, died in an automobile accident April 22, 1995, in Talbot County. He was 64.

Born in Lancaster, South Carolina, Dr. Crenshaw earned his medical degree in 1956 at Duke University School of Medicine, in Durham, North Carolina. After serving two years in the military at Carswell Air Force Base, he completed a fellowship in reproductive physiology at Yale University and then returned to Duke, where he became an associate professor in the medical center's department of pediatrics. A specialist in high-risk obstetrics, Dr. Crenshaw assisted at the birth of more than 5000 babies.

When Dr. Crenshaw came to the University of Maryland in 1980, he developed the high-risk obstetrical program and recruited several young faculty members to join him. Among the areas targeted by his research department were diabetes in pregnant women, delivery of very low birthweight infants, and maternal hemorrhaging disorders. He implemented the program of having an obstetrical specialist attending in the hospital at all times and assisted in the training of almost 100 new obstetricians/gynecologists. Despite these responsibilities, however, he actively participated in the clinical care of patients and took his regular rotation in the on-call schedule.

In addition to his work at the University of Maryland, Dr. Crenshaw established an obstetrics clinic in Easton specializing in the treatment of low-income women with high-risk pregnancies. He was also an active member of Med Chi's Maternal Welfare Subcommittee.

Beloved by his patients and students alike, Dr. Crenshaw will be remembered as a forthright, warm and gracious gentleman who respected all people. He was an extraordinarily knowledgeable physician, superb teacher, and excellent clinician. He will be missed by those fortunate to have had him be part of their lives. May God bless him.

HERBERT L. MUNCIE, JR., M.D.

Howard Wesley Ash, M.D., an ophthalmologist in Frederick for almost 50 years, died March 10, 1995, at the Vindobona Nursing Home in Frederick, Maryland. Originally from Sharon, Pennsylvania, Dr. Ash graduated from Sharon High School and Grove City College. He received his medical degree at the University of Pennsylvania Medical School in Philadelphia. Following a two-year residency at the Atlantic City Hospital in New Jersey, Dr. Ash began the practice of general medicine in Frederick. He later completed postgraduate work in ophthalmology at the Illinois Eye and Ear Infirmary at the University of Illinois in Chicago. Returning to Frederick, he practiced ophthalmology there until his retirement 10 years ago. Former chief of staff at Frederick Memorial Hospital, past president of the Frederick Medical Society, and a 40-year member of Med Chi, Dr. Ash was very active in community affairs. He was 90.

Joseph P. Boggio, M.D., an obstetrician and gynecologist in Baltimore, died March 14, 1995, at his home in Homeland of a liver and intestinal disorder. Dr. Boggio earned his master's degree in pharmacology at the University of Maryland School of Pharmacy and received his medical degree from the Georgetown University School of Medicine. He completed his internship and residency at what is now Mercy Medical Center and was on the staff there and at what is now St. Joseph Medical Center. A fellow of the American College of Obstetricians and Gynecologists, Dr. Boggio was in private practice from 1960 until his retirement in 1993. In addition, he was clinical director of the Druid and Eastern Health Centers for the Baltimore Department of Health until 1974 and a consultant at the Good Shepherd Center. Dr. Boggio was 72.

Henry V. Davis, M.D., a surgeon and general practitioner in Chesapeake City, Maryland, died March 9, 1995, of circulatory illness at the Laurelwood Nursing Home in Elkton. A native of Philadelphia, Pennsylvania, Dr. Davis received his medical degree from the University of Maryland School of Medicine and completed his internship and residency at University Hospital. He completed his surgical residency at the James Walker Memorial Hospital in Wilmington, North Carolina. Dr. Davis practiced in Chesapeake City from 1931 until his retirement in 1978 and was chief of surgery and chief of staff at Union Hospital in Elkton. A member of the International College of Surgeons, Dr. Davis was very active in professional and community organizations. He was 92.

William B. Long Jr., M.D., died January 7, 1995, at Legacy Emmanuel Hospital in Portland, Oregon, due to complications following heart surgery. Born in Westover, Dr. Long graduated from the University of Maryland Medical School in 1937. He began his surgical training at the University of Maryland and completed his formal training at the Lahey Clinic in Boston, Massachusetts, in 1942. A member of the U.S. Army Medical Corps during World War II, Dr. Long was assigned to the Royal Australian Medical Corps and later joined the University of Maryland Medical Unit. He attained the rank of major and was involved in the development of the first M.A.S.H. units. Dr. Long returned to the Eastern Shore in 1946, where he began the private practice of general surgery. He introduced an extension of the University of Maryland general surgical residency training program to Peninsula General Hospital and became an associate clinical professor of surgery. He was chief of surgery and chief of staff at Peninsula General Hospital for 11 years and in 1953, he became the medical director for Symington Wayne Corporation. A former president of the Maryland Chapter of the American College of Surgeons, Dr. Long also served as governor of the American College of Surgeons. In 1960, then-Governor Millard Tawes appointed Dr. Long to the Board of Regents for the University of Maryland. As a member of that board, he represented the professional schools of Baltimore and supported R Adams Cowley, M.D., in developing the Center for the Study of Trauma and the EMS Helicopter Program for the State of Maryland. After his retirement in 1972, Dr. Long moved to Marco Island, Florida. He was 80.

William R. Lumpkin, M.D., a surgeon and former chief of staff at Maryland General Hospital, died of pneumonia on March 30, 1995, at the Edenwald retirement community health care center. Dr. Lumpkin was a 1930 graduate of City College. He earned his pharmacy degree in 1934 and his medical degree in 1938, both from the University of Maryland. He served his internship and surgical residency at Maryland General Hospital. Dr. Lumpkin joined the army as a second lieutenant in 1942 and was severely injured in Sicily while helping wounded soldiers. After a six-month hospitalization, he completed his army medical career as chief of surgery at Erie Proving Ground Hospital in Ohio. Discharged in 1945 as a major, Dr. Lumpkin returned to Baltimore, where he practiced until his retirement in 1981. He was 82.

Uthman Ray Jr., M.D., a west Baltimore family physician and civic activist, died April 14, 1995, at the University of Maryland Medical Center after a lengthy illness. Dr. Ray was a 1951 graduate of what is now Morgan State University and a 1955 graduate of Meharry Medical College in Nashville, Tennessee. He completed his internship at Homer G. Phillips Hospital in St. Louis and served in the Air Force as second commander of the hospital at Dover Air Force Base in Delaware. He was discharged in 1959 with the rank of captain. Very active in professional and community organizations, Dr. Ray was appointed to the Baltimore City Board of Recreation and Parks in 1968 by then-mayor Thomas D'Alesandro, III, a position which he held until 1982. At the time of his death, Dr. Ray had been practicing family medicine in Baltimore for 40 years and was medical director of Irvington Knolls Nursing Home. He was 64.

Robert B. Sasscer, M.D., of Upper Marlboro, Maryland, died March 20, 1995, of cardiovascular disease after a brief illness. Dr. Sasscer graduated from St. John's College in 1937 and earned his medical degree from the University of Maryland School of Medicine. He completed his internship and residency at Mercy Hospital in Baltimore. Dr. Sasscer served in Europe as a captain in the U.S. Army during World War II. Returning to the United States in 1946, he took over his father's family practice until his retirement in 1985. Dr. Sasscer served on the vestry of the Trinity Episcopal Church in Upper Marlboro and was involved with many professional and community projects. He was 78.

Edward J. Simon, M.D., died April 6, 1995, of complications from diabetes, at his home in Havre de Grace, Maryland. A native of New York, Dr. Simon received his undergraduate degree in 1937 from Fordham University and his medical degree in 1941 from Hahnemann University School of Medicine in Philadelphia. He served his residency at French Hospital in New York City. In 1942, Dr. Simon moved to Havre de Grace, where he maintained a general practice until his retirement in 1993. A 40-year member of Med Chi, Dr. Simon was 78.

Cleo D. Stiles, Jr., M.D., an ophthalmologist who retired in 1982, died April 21, 1995, of congestive heart failure, at the Dulaney-Towson Health Care Center in Towson, Maryland. Born in Albany, Georgia, Dr. Stiles earned his undergraduate and medical degrees at Emory University. Following his internship at Maryland General Hospital and residency at Bon Secours Hospital in Baltimore, he practiced general ophthalmology in Frostburg. Returning to Baltimore to train at University of Maryland Hospital as an eye, ear, nose and throat specialist, he later decided to practice only ophthalmology. In addition to his Towson practice, he operated an eye clinic at the Sheppard and Enoch Pratt Hospital. A 40-year member of Med Chi, Dr. Stiles was a member of the American Medical Association, American Academy of Ophthalmology, Southern Medical Association, and Baltimore County Medical Association. He was 90.

Frederick J. Vollmer, M.D., a 40-year member of Med Chi, died March 15, 1995, of a heart attack at St. Agnes Hospital in Baltimore, Maryland. Dr. Vollmer earned his bachelor's degree from Mount St. Mary's College in 1934 and his medical degree from the University of Maryland School of Medicine in 1938. After completing his internship at what is now Mercy Medical Center, he served as a member of the U.S. Army's 42nd General Hospital Unit and was discharged with the rank of major. Dr. Vollmer maintained his general practice in Baltimore from 1945 until his retirement in 1984. In addition to being on the staffs of Mercy Medical Center and St. Joseph Medical Center, Dr. Vollmer was the staff physician for the School Sisters of Notre Dame and the old St. Vincent's Orphanage. He was 83.

No additional information was available at press time for the following members:

Socrates I. Kendros, M.D.
Baltimore City ..... September 17, 1994

Robert M. Marine, M.D.
Anne Arundel County ..... February 25, 1995

Louis H. Moody, M.D.
Prince George's County ..... January 1995

Samuel Rubin, M.D.
Baltimore City ..... February 27, 1995

Robert T. Scanlon, M.D.
Montgomery County ..... February 23, 1995

Raymond K. Thompson, M.D.
Baltimore City ..... December 10, 1994

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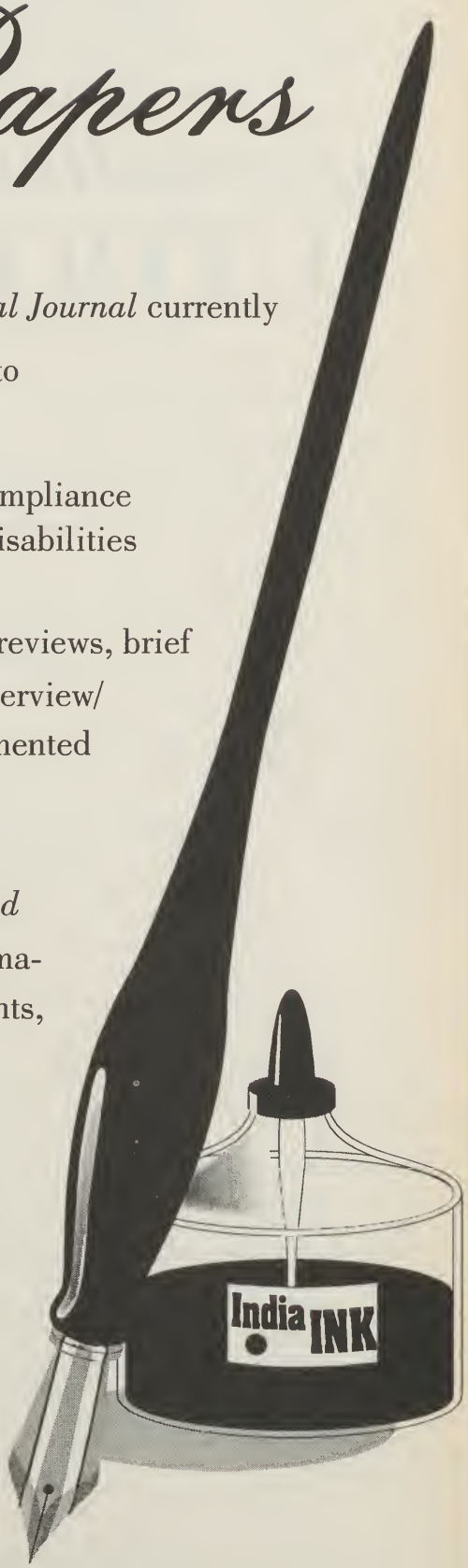
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The Editorial Board of the *Maryland Medical Journal* currently seeks original articles addressing topics related to

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- Assistive Technologies for People with Disabilities

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FAX 410-547-0915.



The Maryland Medical Journal (MMJ) *is a monthly publication of the Medical and Chirurgical Faculty of Maryland. The journal's goals are educational and informative: the publishing of scientific articles (original research, case studies, and review articles) and other technical information, as well as editorials, letters, special articles (evaluations, position papers, reviews of nonscientific subjects), membership and legislative news, continuing medical education notices, and programs and policies of the faculty.*

Information for AUTHORS

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  The letter should include a statement to the effect that all authors have participated in the conception and design of the work and in the writing of the manuscript, and that they take public responsibility for it. The authors should attest to the validity and legitimacy of the data, and acknowledge that they have reviewed the final version of the manuscript and approve it for publication.

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- ***References***—References are limited to those citations noted in the text. References should be numbered consecutively as they appear in the text and should be kept to a minimum (fewer than thirty-five). Personal communications and unpublished data are not acceptable. At a minimum, references should include names of all authors, complete title of the article cited, name of journal abbreviated according to *Index Medicus* (if abbreviation is not known, journal name should be spelled out fully), year of publication, volume number, and first and last page numbers. Sample references are as follows:

  1. Stevens MB. The clinical spectrum of SLE. Md Med J 1991; 10:875–85.
  2. Ropes MW. Characteristics, manifestations, and pathologic findings. In: Ropes MD, ed. Systemic Lupus Erythematosus. Cambridge, MA: Harvard University Press. 1976; 50–4.

- ***Tables***—Tables should be typed on separate sheets of paper, be numbered, and have a brief descriptive title. Data presented in tables should be self-explanatory and should supplement, not duplicate, the text; the Editor reserves the right to edit tables. Authors should be sure that statistics are consistent in both tables and text.

- ***Illustrations***—Illustrations include material that cannot be set in type. Photographic material must be submitted as high-contrast, glossy prints. Drawings and graphs must be done professionally in india ink on high-grade white drawing paper or be computer generated. Identification—including figure number, the title of manuscript, the name of corresponding author, and arrow indicating top—should be typed on a gummed label and affixed to the back of each illustration. Legends for illustrations should be typed on a separate page with numbers corresponding to those on the photographs or drawings. Recognizable photographs of patients are to be masked and should carry with them written permission for publication. Cost of printing color photographs must be borne by the author.

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Checklist

- ☐ Original manuscript and one copy.
- ☐ IBM-compatable disk in WordPerfect, Multimate, Wordstar, or ASCII.
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- ☐ Abstract of 100 to 300 words.
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University of Maryland

For each course, additional information may be obtained by contacting the Program of Continuing Education, University of Maryland School of Medicine, Room 14-011, BRB, 655 W. Baltimore St., Baltimore, MD 21201 (410-706-3956) or by calling the phone number listed after a specific program. FAX 410-328-3103.

Focus on fever, at the Marriott Inner Harbor Hotel, Baltimore, MD. 5 Cat 1 AMA credits. Fee: $75. Info: Celeste Marousek, 410-605-7199. — **June 10**

21st Annual family medicine review course, at the Princess Royale Ocean Suite Hotel, Ocean City, MD. 30 Cat I AMA/AAFP credits. Fee: $550. Info: Althea Pusateri, 410-706-3956. — **June 25–30**

Managing emergency medical services, at the University of Maryland Baltimore County (UMBC). Sponsored by the UMBC Department of Emergency Health Services and the Maryland Institute for Emergency Medical Services System. Info: Dr. Richard Bissell, 410-455-3776. — **July 2–28**

1995 Advanced pre-operative evaluation and planning for complex deformities, at the Pikesville Hilton Inn, Baltimore, MD. 25 Cat 1 AMA credits. Fee: $450. Info: Steven Kaniecki, 410-448-3394. — **Sept 16–19**

Continuously throughout the year

Optimal dosing in chemotherapy: Adoptive control with carboplatin, video tape, monograph and test. Expires March 1996, 3 Cat I AMA credits. Info: 212-924-3044.

Miscellaneous meetings

1995 Risk management program: suit survival/lessons in risk management, sponsored by Medical Mutual Liability Insurance Society of MD. Med Mutual members who attend will receive a 5% discount on 1996 renewal premium. 2 Cat 1 AMA credits. Fee: $40. Info: Toni Davis or Natalie Poole, 410-785-0050 or 1-800-492-0193.

Harbor Hospital Cntr., Baltimore	**June 6**
P. G. Hospital Cntr., Cheverly	**June 8**
Med Chi, Baltimore	**June 13**
St. Mary's Hospital, Leonardtown	**June 14**
Shady Grove Advent. Hospital, Rockville	**June 15**
Washington Advent. Hospital, Takoma Park	**June 21**
Medical Mutual, Hunt Valley	**June 28**
Memorial Hospital, Cumberland	**July 5**
Medical Mutual, Hunt Valley	**July 11**
Montgomery General, Olney	**July 18**
St. Joseph Hospital, Towson	**July 19**
Medical Mutual, Hunt Valley	**July 20**
Carroll County General, Westminster	**July 25**
Peninsula Reg. Med. Cntr., Salisbury	**July 27**

Miscellaneous Meetings (continued)

Third international symposium on maritime health, sponsored by the George Washington University Medical Center, at the Maritime Institute of Technology and Graduate Studies, Baltimore, MD. 14 Cat 1 AMA credits. $1350 (includes lodging and some meals). Info: Karen Mayer, 202-994-3921. — **June 7–9**

2nd Annual intensive review of internal medicine, sponsored by the George Washington University Medical Center, at the Washington Marriott Hotel, Washington, DC. Info: Deborah Grant, 202-994-4285. — **June 7–10**

3rd Annual board review in family medicine, sponsored by the George Washington University Medical Center, at the Marriott Crystal Gateway Hotel, Arlington, VA. 39 Cat 1 AMA/ AAFP credits. Info: Maria Gorrick, 202-994-4285. — **June 24–28**

Lap-assisted vaginal hysterectomy & laparoscopic supracervical hysterectomy at the Minimally Invasive Training Institute, sponsored by St. Joseph Medical Center. 8 Cat 1 AMA credits. Info: 410-337-4843. — **June 27**

Laparoscopic colon resection at the Minimally Invasive Training Institute, sponsored by St. Joseph Medical Center. 6 Cat 1 AMA credits. Info: 410-337-4843. — **June 27**

Diabetic retinopathy: a comprehensive review & update, sponsored by the Retina Institute of Maryland at the Stouffer Harborplace Hotel, Baltimore, MD. 7.5 Cat 1 AMA credits. Fee: $250/physicians; $100/other. Info: 410-337-4500. — **Sept. 15**

6th Biannual gastroenterology board review course, sponsored by the George Washington University Medical Center, at the Grand Hyatt, Washington, DC. Fee and credits TBA. — **Oct. 7–11**

Medical oncology board review course, sponsored by the George Washington University Medical Center, at the Ritz-Carlton Pentagon City, Arlington, VA. Fee and credits TBA. — **Oct. 8–12**

Continuously throughout the year

Fluorescein angiography conference, sponsored by the Retina Center, St. Joseph Hospital, Baltimore, MD, first and third Mondays of each month; 8:00–9:00 am. Fee: none. Info: R. Classon, 410-337-4500.

The Johns Hopkins Medical Institutions

All courses at the Thomas B. Turner Building unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Medical Education, 720 Rutland Ave., Baltimore, MD 21205 (410-955-2959).

Eighth summer institute in environmental health sciences, at The Johns Hopkins University School of Hygiene and Public Health. Info: Denise Barton, 410-955-3537. — **June 5–16**

Advanced pediatric life support, 20 Cat 1 AMA credits. — **June 12–14**

Design and analysis in clinical trials, 15 Cat 1 AMA credits. — **June 15–16**

Ninth annual core content of emergency medicine: a comprehensive review, at the Stouffer Renaissance Harborplace Hotel, Baltimore, MD. $850/physicians before June 30, after $900; $800/residents and fellows before June 30, after $900. — **Aug. 14–20**

The Johns Hopkins Medical Institution (continued)

Third annual progress in hematologic malignancies and bone marrow transplantation and pediatric hematology and oncology for the pediatrician, at the Stouffer Renaissance Harborplace Hotel, Baltimore, MD. $95/physicians and nurses. **Sept. 14**

21st Annual topics in gastroenterology and liver disease, Cat 1 AMA credits available. Fee: $525/physicians; $275/residents and fellows; postmarked before 9/4/95, $495/physicians; $250/residents and fellows. **Oct. 11–13**

Continuously throughout the year

Visiting preceptorship in pediatric critical care medicine. Ongoing five-day preceptorship by appointment. 40 Cat 1 AMA/PRA credits. $600.

The department of radiology and radiological sciences offers several courses in abdominal and obstetrical ultrasound. Info: P. Williams, 410-955-3169.

Visiting physicians. Offered throughout the year for experience in the lab and participation in read-in sessions; by appointment only. 40 Cat 1 AMA/PRA credits. $500.

Johns Hopkins medical grand rounds. Accredited audiovisual continuing education series of case discussions for clinicians; 30 topics per year in five bimonthly programs. Individual and group subscriptions. 40 Cat 1 AMA/PRA credits. Info: 410-955-3988.

Johns Hopkins sports medicine grand rounds. Accredited continuing education series of case discussions by a different presenter on the first Thursday of each month. Info: Carol Kelly, 410-383-0600.

PHYSICIAN'S RECOGNITION AWARD

During March 1995, the physicians listed below received the American Medical Association (AMA) Physician's Recognition Award. Established in 1968, the award's purpose is to encourage physician participation in continuing medical education and to recognize those physicians who have voluntarily completed programs of continuing medical education.

Wisit Boonn, M.D.
Arnold L. Dellon, M.D.
Paul B. Fowler, M.D.
Aryeh L. Herrera, M.D.
Thomas E. Jordan, M.D.
Csaba L. Magassy, M.D.
William P. Magdycz, M.D.
Russell W. Moy, M.D.
Rafik D. Muawwad, M.D.
Marc A. Mugmon, M.D.
Everett G. Schaner, M.D.
Reinhardt H. Schindler, M.D.
Timothy R. Shaver, M.D.
David W. Shea, M.D.
Robert B. Shearin, M.D.
Nicholas T. Spellman, M.D.



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June, 1995
Chickenpox Vaccine Licensed

Background

A vaccine made from live attenuated varicella zoster virus was developed in Japan in the early 1970's. It is licensed in Japan and several other countries. A U.S. vaccine company has developed a varicella vaccine based on the same strain of the virus as the Japanese vaccine. Since the early 1980's, U.S. clinical trials in over 9400 healthy children and over 1600 adults have shown it to be a safe and effective vaccine. Varivax® is now licensed in the U.S. by Merck.

Varicella Vaccine Price, Availability, and Distribution

1. What will the vaccine cost?

The Centers for Disease Control and Prevention (CDC) does not have that information at present. Cost-benefit studies conducted before licensing of the vaccine were projected using a vaccine cost of $35 per dose. These studies indicated that for every dollar spent on varicella vaccine, the U.S. could save $5.40 in direct and indirect costs associated with varicella disease.

2. When will the chickenpox vaccine be available?

The manufacturer has told CDC that the product will become available approximately mid-May, 1996 for general use in the private sector. Varicella vaccine will not be available through public sector health care providers until the varicella vaccine recommendations by CDC's Advisory Committee on Immunization Practices (ACIP) are published, and federal vaccine contracts with the manufacturer are negotiated. ACIP is now finalizing recommendations for use to be published in the Summer of 1995.

Health care providers can continue to receive varicella zoster immune globulin (VZIG) for administration according to the most recent ACIP recommendations (MMWR, 1984; 33(7):84-90, 95-100) or the American Academy of Pediatrics 1994 Red Book, pages 514-517.

3. Who should receive the varicella vaccine?

The Food and Drug Administration has

licensed the varicella vaccine for use in children 12 months of age or older, adolescents, and adults. Children vaccinated at 12 months to 12 years of age require one dose of vaccine; those 13 years of age and older require two doses. The age-appropriate dose and schedule for varicella vaccine administration is given in the package insert. Varicella vaccine is likely to be recommended routinely for all healthy children at 12-18 months of age and for children between 18 months and 12 years of age who do not have a reliable history of chickenpox. Immunization of certain adolescents and adults will be recommended.

4. **Why must the ACIP publish recommendations for varicella vaccine's use before it can be made available through public health clinics?**

   The ACIP officially recommends the use of vaccines to the U.S. Public Health Service (PHS) according to scientific findings and public health needs. These recommendations determine appropriate uses of vaccine for public health care providers and are used by the PHS to determine funding needs to purchase and administer vaccines through public health care providers.

5. **Will varicella vaccine be added to the vaccines available through the Vaccines for Children (VFC) Program?**

   According to law, the ACIP recommends the vaccines to be made available through the VFC Program. The next meeting of the ACIP is scheduled for June, 1995, and use of varicella vaccine in the VFC Program will likely be considered by ACIP at that time.

6. **Is the federal contract price the manufacturer can charge for varicella vaccine capped according to recent federal legislation?**

   No. Newly licensed vaccines are not covered by the legislation that capped vaccine prices.

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Hepatitis B Vaccine Underdosing of Infants Born to HBsAg Positive Women

It has come to our attention that many pediatric providers, including nursery staff and staff of out-patient clinics, may be inadvertently underdosing with hepatitis B vaccine "high-risk" infants, i.e. infants born to hepatitis B surface antigen (HBsAg) positive mothers. Specifically, providers using the pediatric formulation of Recombivax HB (Merck Sharp & Dohme) for the routine immunization of low-risk infants may also be administering this formulation to high-risk infants. The pediatric formulation contains only 2.5 µg per 0.5 mL of hepatitis B surface antigen instead of the 5.0 µg necessary for high-risk infants.

Recent data from an unpublished[1] New York blood center/Centers for Disease Control and Prevention (CDC) study demonstrate efficacy in high-risk infants given the lower (2.5 µg) dose of Recombivax when administered with hepatitis B immune globulin (HBIG). However, failure to appropriately immunize high-risk infants (especially if HBIG was not administered at birth) may result in less than optimal protection, increasing the possibility of perinatal infection and subsequent chronic carriage of the virus. Therefore, administration of HBIG along with an appropriate first dose of vaccine, and timely completion of the three-dose vaccine series, are important in assuring prevention of perinatal hepatitis B transmission.

If inadvertent underdosing of a high-risk infant has occurred for any or all of the three vaccine doses, there is probably no need to restart the series or to readminister the low dose. Rather, assure a follow-up serologic test 3 months following completion of the vaccine series. Screening for hepatitis B surface antigen (HBsAg) and surface antibodies (anti-HBs) will determine either appropriate protection or the need for 1 or 2 additional booster doses of vaccine, spaced 1 month apart.

Recommended Doses of Currently Licensed Hepatitis B Vaccines

To obtain the correct dosage for these high-risk infants, use any of the formulations listed in Table 1, "Recommended Doses of Currently Licensed Hepatitis B Vaccines". This table may help providers determine microgram doses of hepatitis B vaccine for other age groups or patient status. Manufacturer and microgram dosages or exact name of product and milliliter dose (e.g., Recombivax High-Risk Infant Formulation 0.5 mL) of hepatitis B vaccine and dosages of HBIG should be carefully documented in both hospital (birth) records and in the immunization booklets given to mothers at discharge. These immunization booklets are provided in bulk quantity at no cost by the Maryland Department of Health and Mental Hygiene to delivery hospitals.

Vaccine dosing questions have arisen as to the difference between using the Engerix-B pediatric dose (10 µg per 0.5 mL dose) versus the adult dose (20 µg per 1.0 mL dose) for adolescents (see Table 1). While the pediatric formulation has been newly licensed for use in this age group, both formulations are still acceptable. The adult dose simply has twice the antigen load, twice the volume, and is more expensive. The adult formulation is not, however, licensed to be split into two 10 µg per 0.5 mL doses.

---

[1]May appear in the next issue of the CDC's Immunization Practices Advisory Committee (ACIP) statement on hepatitis B prevention.

Recommended Doses Of Currently Licensed Hepatitis B Vaccines

Patient's Age/Status	Vaccine				
	Recombivax HB[a,f] (Merck Sharp & Dohme)			Engerix-B[b,f] (SmithKline Beecham)	
	Pediatric Formulation (Brown Cap) 2.5 μg/0.5 mL	High-Risk Infant/ Adolescent Formulation (Yellow Cap) 5 μg/0.5 mL	Adult Formulation (Green Cap) 10 μg/1.0 mL	Pediatric Dose (Blue Cap) 10 μg/0.5 mL	Adult Dose (Orange Cap) 20 μg /1.0 mL
Infant born to HBsAg+Mother[c]	5 μg (1.0 mL)	5 μg (0.5 mL)	5 μg (0.5 mL)	10 μg (0.5 mL)	
Infant born to HBsAg-Mother[d]	2.5 μg (0.5 mL)	2.5 μg (0.25 mL)	2.5 μg (0.25 mL)	10 μg (0.5 mL)	
1-10 Years[e]	2.5 μg (0.5 mL)	2.5 μg (0.25 mL)	2.5 μg (0.25 mL)	10 μg (0.5 mL)	
11-19 Years[e]	5 μg (1.0 mL)	5 μg (0.5 mL)	5 μg (0.5 mL)	10 μg (0.5 mL)[g]	20 μg (1.0 mL)
Adult[e]		10 μg (1.0 mL)	10 μg (1.0 mL)		20 μg (1.0 mL)

Note: Always select dose based on micrograms (μg) you wish to administer. Never select dose based on volume (mL or cc) alone; The same 0.5 mL dose may contain 2.5, 5 or 10 μg of hepatitis B surface antigen.

[a] "If the suggested formulation is not available, the appropriate dose can be achieved from another formulation provided that the total volume of vaccine administered does not exceed 1 mL" (package insert).

[b] Product is only licensed for use as indicated on the label.

[c] Recommended schedule: HBIG and vaccine at 0, 1 and 6 months.

[d] Recommended schedule: birth, 1-2 months, 6-18 months.

[e] Recommended schedule: 0,1,6 months for Recombivax. Engerix-B is also licensed for an alternate dosing schedule at 0,1,2 & 12months. Add HBIG with first dose of either vaccine if post-exposure prophylaxis.

[f] If delay between doses, do not restart series; give next dose as soon as possible, with a minimum interval of 1 month between dose 1 and dose 2, and a minimum interval of 2 months between dose 2 and dose 3.

[g] Newly licensed for adolescents. "When the alternate schedule [0,1,2,12 mos.] is used for adolescents, the 20 μg/1.0 mL dose should be used" (package insert).

Maryland Department of Health and Mental Hygiene, Epidemiology & Disease Control Program, Hepatitis B Prevention Section, 5/01/95

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Hearing loss may significantly increase the apparent level of psychopathology in geriatric patients. In a crossover design, 21 elderly patients (mean age, 72.3 years) with stable psychotic illness (17 with schizophrenia or schizoaffective disorder; 4 with major affective disorder) were examined for psychiatric functioning and speech discrimination. Although all patients passed a baseline hearing examination that used tuning forks and an otoscope, they displayed less psychopathology when tested (Mini-Mental State, Brief Psychiatric Rating Scale, and Clinical Global Impression) wearing a functional hearing aid. Investigators concluded mild hearing loss could lead to substantial overestimation of psychopathology and possibly to unnecessary treatment (*Am J Psychiatry* 1995;152:629-631).

Concomitant use of nonsteroidal anti-inflammatory drugs (NSAIDs) and antihypertensive agents may be associated with loss of blood pressure control. NSAIDS appear to reduce antihypertensive efficacy by inhibiting prostaglandin synthesis, resulting in increased sodium reabsorption and water retention. The interaction occurs with antihypertensive agents whose mechanisms of action involve counter-regulation of vasodilatory prostaglandins (thiazide and loop diuretics, beta- and alpha-adrenergic blockers, and ACE inhibitors). Until long-term effects of coadministration are known, physicians should monitor blood pressure frequently in patients taking NSAIDs in combination with diuretics, beta-blockers, or ACE inhibitors, and modify dosages if warranted. Physicians also should consider that antihypertensive-treated patients may take over-the-counter NSAIDs such as ibuprofen or naproxen sodium (*Am Fam Physician* 1995;51:849-856).

To examine mechanisms that may be involved in the putative association between psychological stress and increased risk of atherosclerosis, researchers at the University of Pittsburgh School of Medicine measured serum lipid concentration, hemoconcentration, plasma fibrinogen concentration, and plasma or whole-blood viscosity in healthy young adults subjected to short-term mental stress. Compared to unstressed controls, stressed subjects had significant increases in heart rate; blood pressure; hematocrit; hemoglobin level; total protein concentration; total, low-density, and high-density lipoprotein cholesterol; plasma viscosity; and estimated whole-blood viscosity. In addition, they showed significant reductions in plasma volume. Believing the study to be the first to provide evidence that **brief psychological stress increases both plasma and blood viscosity**, the authors note that other recognized risk factors for atherosclerosis (smoking, serum lipid levels, age, gender) also are associated with increased blood and plasma viscosity (*Arch Intern Med* 1995;155:615-620).

After childhood vaccination was instituted in the 1950s, diphtheria was controlled for approximately 30 years. Beginning in 1990, however, an epidemic re-emerged in the New Independent States (NIS) of the former Soviet Union and has increased two- to tenfold each year, from 839 reported cases in 1989, to 47,802 in 1994, including 1746 deaths. **The World Health Organization considers the rapidly expanding diphtheria epidemic to be an international public health emergency.** Vaccine-induced immunity to diphtheria wanes unless periodic boosters are given, and serologic studies indicate 20% to 60% of adults in the United States, Western Europe, and the NIS may be susceptible. At least 20 cases of imported diphtheria were reported in European countries in 1994, and two cases were reported in U.S. citizens who live or traveled in the NIS. The Centers for Disease Control thus considers the epidemic to pose a risk for importation into the United States (*MMWR Morb Mortal Wkly Rep* 1995;44:177-181).

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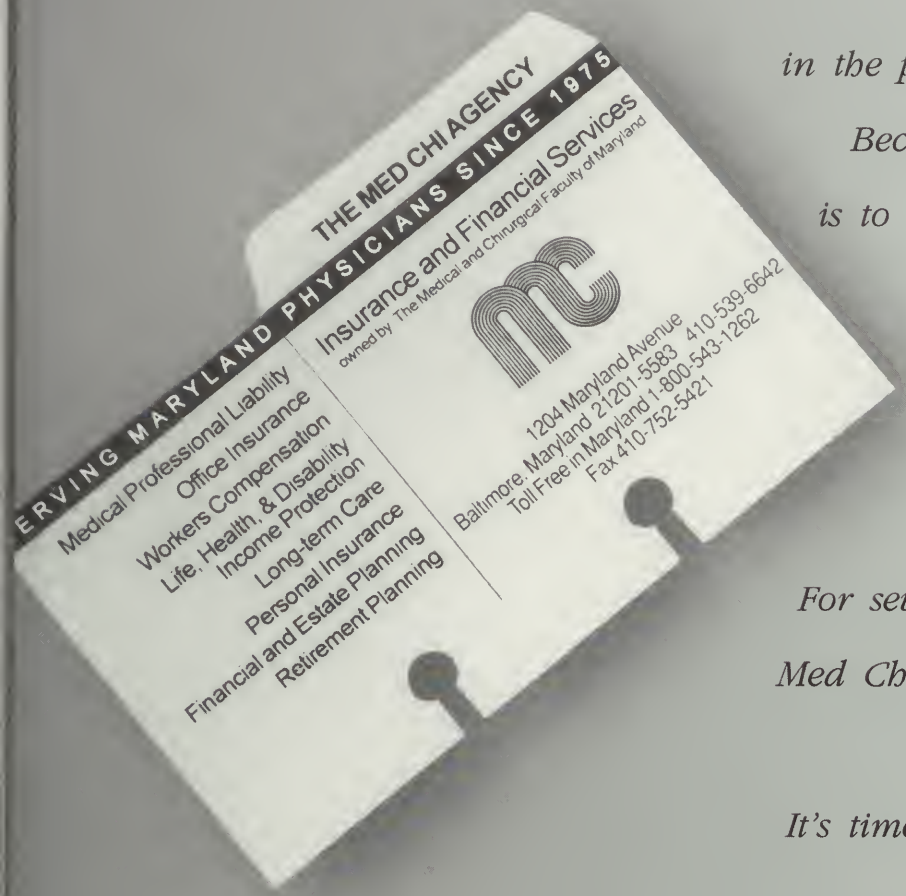
In an excellent review of antihypertensive withdrawal syndrome (AWS), the authors describe signs and symptoms that may be associated with abrupt discontinuation of beta-blockers, centrally acting drugs, and calcium channel blockers. These include CNS effects (nervousness, agitation, insomnia, anxiety, headaches), GI symptoms (ranging from mild nausea to anorexia, abdominal cramps, and vomiting), cardiovascular effects (tachycardia, increased blood pressure), and diaphoresis. Cardiovascular morbidity may include increased severity and frequency of angina; development of arrhythmia, acute myocardial infarction, and severe hypertension; and sudden death. Those most at risk for AWS include patients with underlying coronary heart disease or angina. **To prevent antihypertensive withdrawal syndrome, antihypertensive drugs should be discontinued gradually over a two- to four-week period** (*Arch Fam Med* 1995;4:266-270).

It has been suggested that some antidepressant drugs may be associated with an increased risk of suicide. **Results of a population-based study involving more than 170,000 people who received at least one prescription for any of 10 antidepressants indicate that the type of antidepressant used has little to do with the suicide risk.** Case-control analysis of the 143 suicides that occurred within six months of the person's taking antidepressant medication showed major risk factors for suicide were male sex, history of suicidal feelings, and number of previously prescribed antidepressants. In addition, patients who had received their last antidepressant prescription within the past 30 days were more likely to commit suicide than those who had received their prescription 30 or more days previously. Although study data showed a higher rate of suicide associated with fluoxetine (Prozac), investigators concluded that the increased risk may be explained by selection bias and that their data do not support the proposition that fluoxetine may trigger an emotional state that increases suicide risk (*BMJ* 1995;310:215-218).

A chart review study of 66 fetuses alive at the time of maternal admission indicates that **antenatal obstetrical judgment of viability may influence perinatal survival of extremely low birthweight (500 to 749 g) infants.** Factors evaluated were estimated age and weight of the fetus, lethal fetal anomalies, and parental requests. After controlling for birthweight and gestational age, fetuses considered viable were 18 times more likely to survive than those considered nonviable, presumably because they received more aggressive care. The authors conclude that, by preventing fetal deaths, favorable antepartum judgments of viability may increase the overall number of live-born, very low birthweight infants and thus influence the denominator used in evaluating neonatal morbidity and mortality (*Am J Public Health* 1995;85:362-366).

Results of a study comparing 73 children with meningitis hospitalized during a 3-year period with 74 age- and sex-matched controls hospitalized for abdominal surgery suggest that **exposure to tobacco smoke may be associated with development of bacterial meningitis.** The authors speculate that passive smoking may produce changes in immune-defense mechanisms similar to those found in smokers (*J Am Board Fam Pract* 1995;8:95-95).

A number of medical organizations, including the North American Spine Society, American Academy of Neurology, American Academy of Electrodiagnostic Medicine, American Academy of Orthopaedic Surgeons, and American Academy of Physical Medicine and Rehabilitation have declined to endorse the clinical practice guidelines for the assessment and treatment of acute low back problems published last December by the Agency for Health Care Policy and Research (AHCPR publication no. 95-0642). The American Academy of Physical Medicine and Rehabilitation declined to support the guidelines because of concerns about the "limited literature review and limited amount of scientific evidence upon which the AHCPR relied in drafting this Guideline" (*Arch Phys Med Rehabil* 1995;76:294).



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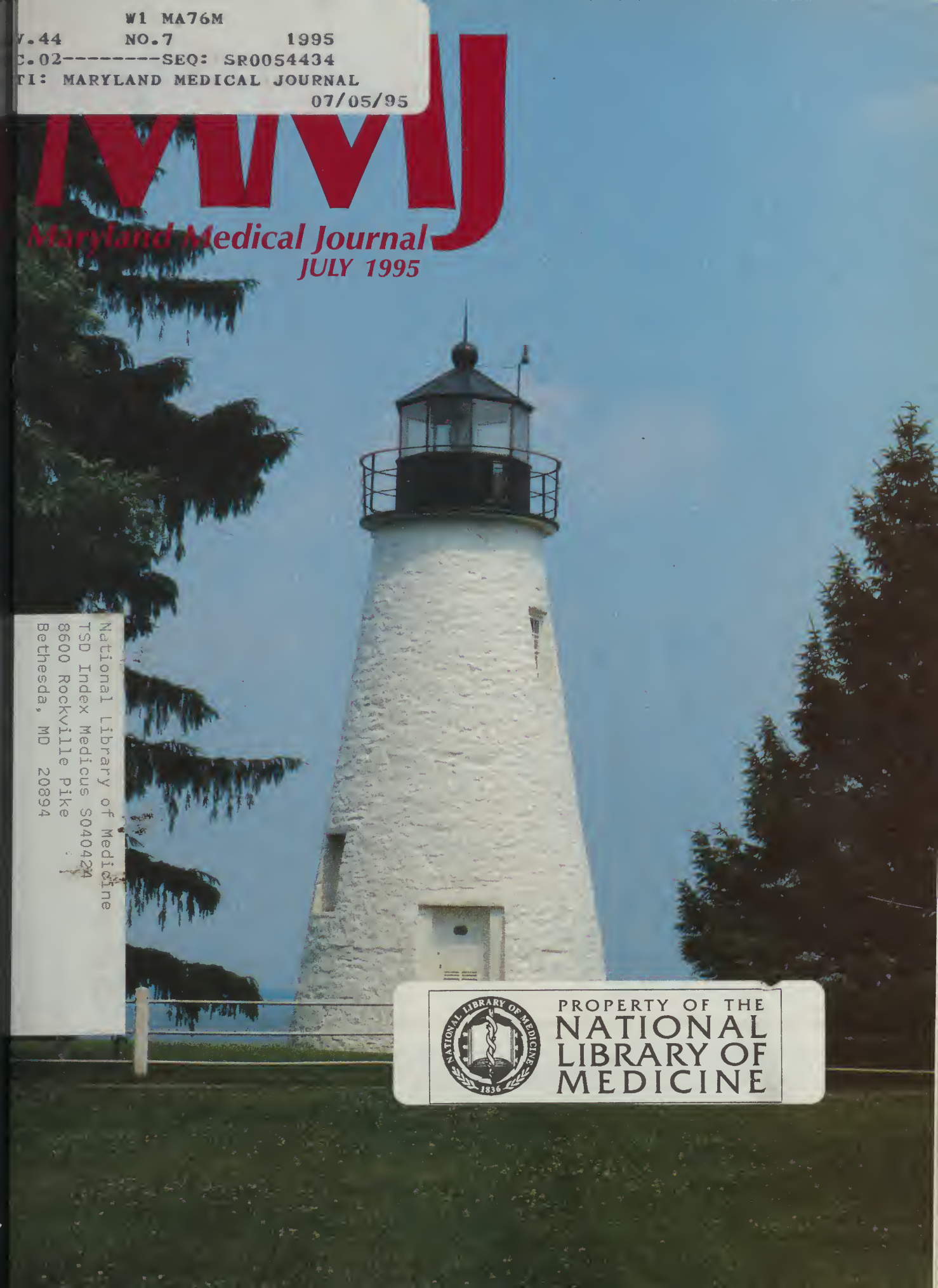
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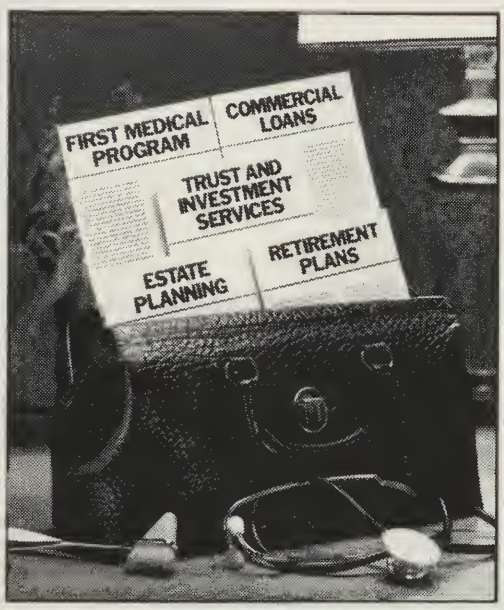
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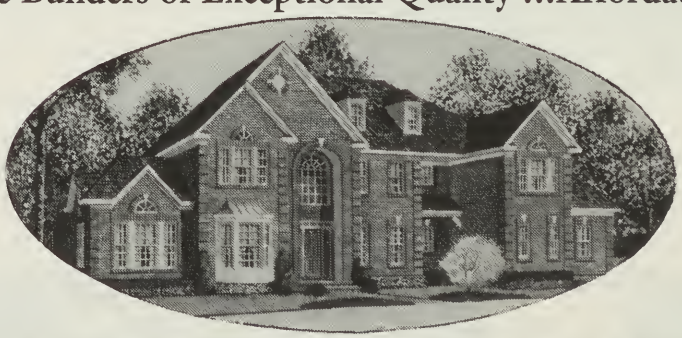
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Chief Executive Officer's Newsletter

July 1995

Council Chairpersons Selected

The following Med Chi physicians have been selected to serve as council chairpersons for 1995-1996:

Bylaws - *J. Ramsay Farah, M.D.*
Ethical and Judicial Affairs - *Marianne Benkert, M.D.*
Medical Education - *Henry Wagner, M.D.*
Scientific Affairs - *Ronald Fishbein, M.D.*
Medical Services - *Joseph Fastow, M.D.*
Legislation - *J. Leonard Lichtenfeld, M.D.*
Medical Affairs - *Beverly Collins, M.D.*
Planning and Development - *Michael Dobridge, M.D.*

House of Delegates/ Reference Committee Meetings

The next meeting of the House of Delegates and Reference Committees will be held on Saturday, July 15, 1995, at the Med Chi Faculty Building, Baltimore, MD, at the following times:

Reference Committees 9:00 am - 11:00 am

House of Delegates Registration 1:30 pm - 2:00 pm
House of Delegates begins promptly at 2:00 pm

1995 Med Chi Semiannual Meeting - Earn 16 hours CME!

The 1995 Med Chi Semiannual Meeting will be held Friday, September 8, through Sunday, September 10, at the Princess Royale Oceanfront Hotel and Conference Center, Oceanfront at 91st Street, Ocean City, Maryland.

To increase the number of CME credits available at the semiannual meeting this year, CME sessions will be held concurrently with business meetings. Physicians can earn up to 16 CME hours over three days. See the tentative schedule following this issue of the *Chief Executive Officer's Newsletter (CEON).*

Med Chi has reserved a block of rooms at the following group rates: $126 per night for a single/double occupancy oceanview suite and $169 per night for a single/double occupancy oceanfront suite (tax and incidentals not included). Two- and three-bedroom condos are also available. To reserve a room, call the Princess at 410-524-7777 or 1-800-4ROYALE (1-800-476-9253), and tell them you will be attending the Med Chi meeting. Please reserve early—reservation deadline is August 8, 1995, but rooms may fill prior to this date.

Med Chi Condemns Harassment of Physicians

A harassment campaign has recently been initiated against a number of physicians in Montgomery County. Physicians targeted by an anti-abortion group have become victims in a smear campaign — flyers are being placed in their neighborhoods publicizing personal information about them and their families. Med Chi is deeply concerned about this situation and urges anyone who has become a victim of such harassment, or knows someone who has, to call Special Agent Larry Russell of the FBI at 202-252-7712.

DHMH - Request for Information

A letter from J. Richard Lilly, M.D., president, Med Chi, which urges physicians to cooperate with the recent request for information from the Department of Health and Mental Hygiene (DHMH), immediately follows this issue of the *CEON*.

Change in Law for Prescribing of Amphetamines and Methamphetamines

As of July 1, 1995, Maryland physicians will no longer be required to seek specific approval from the Med Chi Committee on Drugs for the prescribing of amphetamines or methamphetamines. On April 11, 1995, Governor Glendening signed into law HB 1260, which repealed the statute and the regulation requiring approval. HB 1260 was the result of several years of work by Med Chi after the Med Chi Committee on Drugs concluded that the existing regulations were outdated, and, in fact, hindered physicians making appropriate use of these drugs in accordance with current pharmaceutical knowledge. If you have any questions regarding the statutory change, you may call Stephanie Seipp at 410-539-0872 or 1-800-492-1056, ext. 315.

Attention WWII Veterans

If you are a veteran of World War II and would be willing to discuss your experiences as a physician during that era, please contact Mary Ann Ayd, Managing Editor, *MMJ*, at 410-539-0872 or 1-800-492-1056, ext. 305.

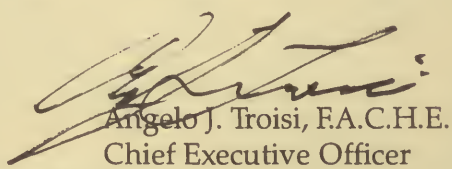
Capitation Workshop to Be Offered

Med Chi invites you to attend a Conomikes' Workshop on Capitation being held Wednesday, September 20, 1995, from 1:00 pm - 4:00 pm, at the Med Chi Faculty Building. Tom Smolic, Staff Associate with Conomikes Associates, Inc., a practice management consultant group, will present the workshop. He will cover the following topics: Preparing Your Practice for Capitation, Developing a Methodology for Evaluating Capitation Rates, Managing the Risk, and Managing Your Practice.

Registration will be $50 for Med Chi members and $100 for nonmembers. Preregistration is required. Contact Joan Mannion at 410-539-0872 or 1-800-492-1056, ext. 319 for additional information or to obtain a registration form.

Calling All Medical Musicians

The VA-National Medical Musical Group (MMG) is recruiting new members for its chorus and symphony orchestra. If you sing or play a musical instrument you may apply. The MMG plans to give its annual concert November 10, 1995, at the DAR Constitution Hall, Washington, DC. Following that, the group will conduct a concert tour of France, November 11-19. Participation is open to physicians, nurses, other medical personnel, and students. The tour of France will cost $1,425 including airfare from Washington, first class hotels, sightseeing, all breakfasts, a visit to the Eiffel Tower and a cruise on the Seine River. For information on auditions or travel to France as an MMG performer or companion, write to: MMG, 1700-17th Street, N.W., Ste. 508, Washington, DC 20009, or call Mrs. Nevart Haley at 202-667-3879.



Angelo J. Troisi, F.A.C.H.E.
Chief Executive Officer



Medical
and Chirurgical Faculty
of Maryland

President's Letter

Prepared by the President of the Medical and Chirurgical Faculty of Maryland as a service to members

Dear Colleague:

As you read in the June issue of *Maryland Medical Journal* (1995;44:474-476), the Department of Health and Mental Hygiene (DHMH) is asking all physicians licensed in Maryland to provide information about their medical practice via a form that will be included with the medical license renewal packet beginning this month. The information is being requested so that state agencies (DHMH, the Board of Physician Quality Assurance, the Maryland Health Care Access and Cost Commission, and the Maryland Health Resources Planning Commission) can better estimate the demand for medical services and the supply of resources, which should result in more effective allocation of state and federal funds.

On behalf of Med Chi, I urge all physicians to cooperate with the request for information by answering all questions and returning the completed forms. We have been assured that the Board of Physician Quality Assurance reviewed the questions to request only necessary information and that in future years, physicians will only be asked to update information they have already supplied. The DHMH has assured us that the data collection effort is not intended to restrict or regulate the training, location, reimbursement, or medical practice patterns of any individual physician. Finally, we have been assured that the agencies involved in the data collection project will control access to and maintain the confidentiality of sensitive data: collected data will only be used for mandated purposes, and nonpublic data will be released to the public as aggregate data only.

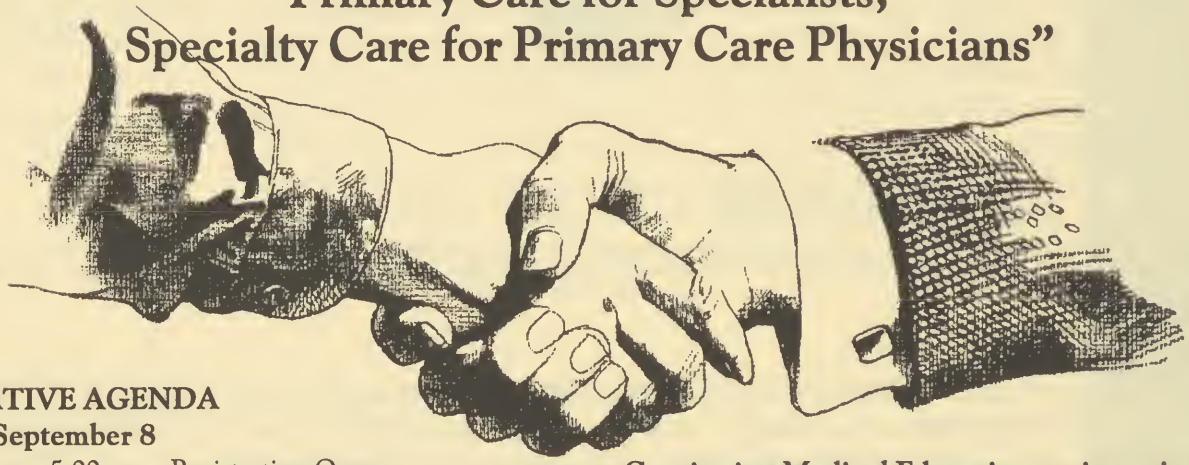
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TENTATIVE AGENDA

Friday, September 8

11:30 am - 5:00 pm	Registration Open
12:00 pm - 7:00 pm	Exhibits Open
12:30 pm - 1:00 pm	House of Delegates Registration
1:00 pm - 4:00 pm	House of Delegates Meeting
1:00 pm - 4:00 pm	CME Sessions
4:00 pm - 4:30 pm	Break
4:30 pm - 6:00 pm	CME Sessions
6:00 pm - 7:00 pm	Welcome Reception

Saturday, September 9

7:30 am - 5:00 pm	Registration Open
8:00 am - 3:00 pm	Exhibits Open
7:30 am - 9:00 am	Innovative Financial Strategies
8:00 am - 9:00 am	CME Sessions
9:00 am - 12:00 pm	Reference Committees
9:00 am - 10:00 am	CME Sessions
10:00 am - 11:00 am	Break
11:00 am - 12:00 pm	CME Sessions
12:00 pm - 1:00 pm	Lunch
1:00 pm - 2:00 pm	Keynote Address
2:00 pm - 3:00 pm	Break
3:00 pm - 6:30 pm	CME Sessions

Sunday, September 10

NO EXHIBITS ON SUNDAY

8:00 am - 12:00 pm	Registration Open
8:30 am - 9:00 am	House of Delegates Registration
9:00 am - 12:00 pm	House of Delegates Meeting
8:00 am - 12:00 pm	CME Sessions

Continuing Medical Education topics to include:

- Anxiety/Depression: Primary to Specialty Care
- Hepatitis in Children: Cooperative Interventions
- Epilepsy in Children: Pediatricians and Neurologists in Collaboration
- Cardiac Maintenance: Primary and Specialty Support
- Physician Responsibility in Completing Death Certificates
- Child Abuse: Every Physician's Concern
- Recognition and Management of Glaucoma
- Collaboration in Treating Prostatic Cancer
- New Cardiac Interventions for MI: What Every Doctor Needs to Know
- Collaborative Practices
- How to Help Your Patients Stop Smoking
- Plenary Session: Primary Care Physicians and Specialists Working Together
- Detecting Breast Cancer
- The Ailment that Crosses all Specialties: Lower Back Pain
- Nothing to Sneeze At: Allergies
- Minor Surgical Techniques for All Physicians
- Minor Sprains and Fractures: Treatment/Referral?
- When Snoring is No Laughing Matter
- Wound Care Dynamics and Evolving Strategies
- Keeping the Primary Care Doctor Involved: Opioid Addiction
- Information Sources for Primary and Specialty Doctors
- Suit Survival/Lessons in Risk Management

Look for more specific information in the next issue of the *Maryland Medical Journal*, and watch your mail for a preliminary program.

Make your hotel reservations now!
Call the Princess at 410-524-7777 or 1-800-4ROYALE.

Reservation deadline at the Princess Royale is August 8, 1995, but Med Chi's block of rooms may fill up prior to this deadline. Identify yourself as a Med Chi meeting attendee to receive Med Chi's special rates.

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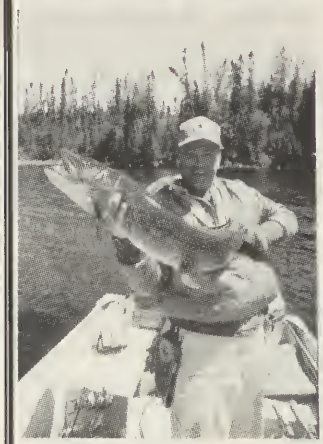
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Members in the News



H.A. ARFAA, M.D., president-elect of the Harford County Medical Society, was elected president of the medical staff and named chairperson of the medical executive committee at Harford Memorial Hospital in Havre de Grace, Maryland. Dr. Arfaa completed his internship and then residencies in general surgery, and plastic, hand, faciomaxillary, and reconstructive surgery in New York and New Jersey. He has served as chief of plastic, hand, faciomaxillary, and reconstructive surgery at both Harford Memorial and Franklin Square hospitals. Dr. Arfaa has previously served two terms as president of the medical staff, chairman of the medical executive committee, and member of the board of directors at Harford Memorial Hospital. He is a fellow of the International College of Plastic and Reconstructive Surgeons and is a member of the board of directors of the Upper Chesapeake Health System.



JOHN BARRETT, a medical student at the Uniformed Services University of the Health Sciences, was awarded the AMA/Glaxo Achievement Award. He was one of 25 medical students honored for exceptional leadership abilities in medicine or achievements in nonclinical activities. He is active with the Family Medicine Interest Group and Students for AIDS Education, was elected president of the Emergency Medicine Interest Group, and has been involved in many community service projects. He was the top honor graduate for the U.S. Army's Basic Flight Surgeon School. Active in the Military Medical Student Association (MMSA), Mr. Barrett is the editor of the *Journal of the MMSA*.



OSWALD J. BURTON, M.D., was inducted as a fellow of the American College of Physicians during its 76th annual session held in March in Atlanta, Georgia. Dr. Burton has been in private practice in Salisbury, Maryland, since 1954. In 1994, he was elected a fellow of the Royal College of Physicians in Edinburgh. He is a past chief of the department of medicine and a past president of the medical staff at Peninsula Regional Medical Center. Board certified in internal medicine, Dr. Burton is a graduate of the University of Edinburgh, Scotland. He trained in Erie, Pennsylvania; Milford, Delaware; and Aylesbury, England. He served with the British Army 9 Commando and with the Gurkhas in the Middle East and in Italy during World War II.



BENJAMIN V. DEL CARMEN, M.D., was elected president of the medical staff at St. Joseph Medical Center in Towson, Maryland, and will serve as chairperson of the medical executive committee and as a member of the board of trustees. A graduate of the Medical School at the University of the Philippines, Dr. Del Carmen completed rotating internships at the Philippines General Hospital and St. Joseph Hospital. He completed a surgical residency at St. Joseph Hospital and a fellowship in oncology at the University of Wisconsin Hospital. Board certified in general surgery, Dr. Del Carmen is a fellow of the American College of Surgeons, Southeastern Surgical Congress, and American Society of Abdominal Surgeons. He is a past president of the Baltimore County Medical Association.



HAROLD I. EIST, M.D., is the president-elect of the American Psychiatric Association. Dr. Eist received his medical degree from the University of Alberta Medical School in Edmonton, Canada. He completed a rotating internship and pediatric residency at the University of Alberta Hospital, a residency in psychiatry at the University of Minnesota, and child psychiatry fellowships at the University of Minnesota and the Amherst Wilder Child Guidance Clinic, in St. Paul, Minnesota. Dr. Eist is currently in the full-time private practice of child, adolescent, and adult psychiatry in Bethesda, Maryland, and is the medical director of Montgomery Child and Family Health Services, Inc. In addition, he is an assistant professor and lecturer at Howard University in Washington, DC, and is on the faculty of Washington School of Psychiatry. A former president of the Washington Psychiatric Society, Dr. Eist was the long-time director of the DC Institute of Mental Hygiene. He is board certified in psychiatry and

neurology, is a member of many community and professional organizations, and has published more than 200 articles, commentaries, and editorials.



EDWARD F. LEWISON, M.D., the inventor of rayable gauze (the x-ray opaque surgical sponge), was recently honored for his work in breast cancer surgery by the American Cancer Society Greater Baltimore Unit. An associate professor emeritus of surgery at The Johns Hopkins University School of Medicine, Dr. Lewison received his medical degree from Hopkins and helped found the Tumor Clinic at Johns Hopkins Hospital; the clinic later became the Breast Cancer Clinic, where he served as chief for more than 25 years. The library at the Johns Hopkins Oncology Center is named in his honor. Former president of the American Cancer Society, Maryland Division, Dr. Lewison is an active honorary life member of the board of directors and the executive committee of the American Cancer Society, Maryland Division, and he is medical director-at-large of the national board of directors of the American Cancer Society. He has written numerous scientific papers and co-authored three books on breast cancer. A diplomate of the American Board of Surgery, Dr. Lewison is a fellow of the Royal Society of Medicine, the American College of Surgeons, and the American Medical Association.



JOHN B. LITTLETON, M.D., was recently installed as president of the Maryland Academy of Family Physicians. Born in Virginia, Dr. Littleton graduated from the University of Maryland School of Medicine and completed his internship at the University of Maryland Hospital. He is the founder and chief executive officer of the Medical Health Group, a family practice-oriented multispecialty group in Baltimore County. Board certified in family medicine, Dr. Littleton has served in several official capacities for the Maryland Academy of Family Physicians and has been very active in health care reform in Maryland.



DAVID A. NAGEY, M.D., Ph.D., director of maternal-fetal medicine at the University of Maryland Medical Center, was general chairman of the annual convention of the American College of Obstetricians and Gynecologists in San Francisco. Dr. Nagey received his Ph.D.in bioengineering and his medical degree from Duke University in Durham, North Carolina. He was chief resident in the department of obstetrics and gynecology and a fellow in the division of maternal-fetal medicine at Duke University Medical Center. A diplomate of the American Board of Obstetrics and Gynecology and the Division of Maternal-Fetal Medicine, American Board of Obstetrics and Gynecology, Dr. Nagey is an associate professor in the department of obstetrics and gynecology at the University of Maryland School of Medicine. He is the medical director and principal investigator of the Maryland Perinatal Database and an adjunct associate professor in the department of electrical engineering at the University of Maryland at Baltimore County and in the department of maternal and child health at The Johns Hopkins University School of Hygiene and Public Health. A fellow of the American College of Obstetricians and Gynecologists and past president of the Obstetrical and Gynecological Society of Maryland, Dr. Nagey is active in many community and professional organizations. He is the author or coauthor of more than 90 articles, publications, and book chapters.



ROSS J. VanANTWERP, D.O., M.P.H., a specialist in internal, preventive, and emergency medicine, was recently appointed to a U.S. Public Health Service panel of the Agency for Health Care Policy and Research that is developing clinical practice guidelines on screening for colorectal cancer. Dr. VanAntwerp received his medical degree from the Michigan State University College of Osteopathic Medicine. He served a rotating internship and a two-year residency in internal medicine at Mount Clemens General Hospital in Mt. Clemens, Michigan, and completed his internal medicine as well as a clinical preventive medicine residency at Hopkins. He is a diplomate of the National Board of Examiners, the American Osteopathic Board of Internal Medicine, and the American Board of Preventive Medicine, and a fellow of the Society for Laser Medicine

and Surgery. A former paramedic, Dr. VanAntwerp continues to attend in the emergency department of Franklin Square Hospital. He also serves on the board of trustees of the Maryland Association of Osteopathic Physicians and is a member of numerous professional societies.



JOSEPH W. ZEBLEY, III, M.D., was named Family Doctor of the Year for 1995 by the Maryland Academy of Family Physicians. Dr. Zebley earned his bachelor of arts degree at The Johns Hopkins University before attending the Université Louis Pasteur Faculté de Medecine in Strasbourg, France, for four years. He transferred to the University of Maryland School of Medicine and completed his residency in family medicine at the University of Maryland Hospital. He is a diplomate of the American Board of Family Medicine with a Certificate of Added Qualifications in geriatrics and a fellow of the American Academy of Family Physicians. Dr. Zebley is the medical director of Towson Medical Associates, a family practice-oriented multispecialty group, and teaches in the department of family medicine at the University of Maryland School of Medicine. A former president of the Maryland Academy of Family Physicians, Dr. Zebley is a member of several professional societies.

Erratum
On page 349 in the May 1995 issue, Howard County Medical Society President Dr. Russel O. Schub should have been designated a doctor of osteopathy. *Maryland Medical Journal* regrets the error.

COLUMNOSCOPY

In March 1995, Bethesda gastroenterologist Peter N. Kaufman, M.D., endoscopically examined a century-old patient with a cast-iron constitution. Given the patient's age and unusual history, however, Dr. Kaufman knew the exploratory examination would reveal clinical abnormalities. Carefully inserting the probe, he watched the monitor intently. The images were clear and perfectly legible: Dr. Kaufman could read with ease words such as *London*, *parquetry*, and *asphalte*. Probing further, Dr. Kaufman eventually uncovered an 1883 edition of *Building News & Engineering Journal*. The patient, rigid during the entire examination, is expected to remain immobile. The diagnosis? *Tempis capsulitis.*

Dr. Kaufman's "patient" was a column in the National Building Museum in Washington, DC. At least 20 of the columns that surround the museum's Great Hall were used as time capsules by the builder, Civil War general Mongtomery C. Meigs, who left an inventory of records that were placed into some of the columns before workers capped them during the building's construction in the 1880s. Dr. Kaufman scoped one column through a small hole made by vandals in the 1960s. Although it had been possible to feel the column's papery contents by inserting a finger into the opening, the endoscope showed that the column contained such artifacts as manufacturing catalogs for building materials, architectural drawings, and a bundle of newspapers tied with twine. The contents of the other columns, which remain intact, have not been seen.



Peter Kaufman, M.D., examines a nineteenth century time capsule at the National Building Museum in Washington, DC.
Photo by Valerie Russel, courtesy of the National Building Museum.

The National Building Museum, located at 401 F Street NW, is open Monday through Saturday, 10 a.m., to 4 p.m., and Sunday, noon to 4 p.m. Although the endoscope has been removed from the premises, interested physicians may confirm Dr. Kaufman's diagnosis by digital examination.

LETTERS TO THE EDITOR

The subject was radon

I wish to respond to Dr. Baker's editorial (*Md Med J* 1995;44:193–194) in which he critically reviewed our article "Radon in Anne Arundel County" (*Md Med J* 1995;44:204-209). Dr. Baker claimed the article was intended to "play on the fear of the unfamiliar." He bases this opinion on our omission of general cancer prevention information and on his own views on published radon risk assessments. I feel compelled to point out that the article was on the subject of radon, not on general cancer prevention. Far from playing to the fear of the unfamiliar, this agency has made it a priority to render familiar radon and other changeable cancer risks. In a publication aimed at physicians, we feel sure that there are few who are unaware of the risks of tobacco use. Very simply, that was not the topic of the article. Radon was.

We are aware that some of the occupational studies on uranium miners may have been flawed. We reviewed the available literature and the published risk assessment data. Although there is wide variation in opinion on radon risk, we reported on the published data accurately and objectively.

Our report clearly demonstrates that radon levels in Anne Arundel County cannot be the "smoking gun" for our high lung cancer death rate. We continue to urge testing of dwellings for radon because it is a risk that can be easily and cheaply reduced. We believe this to be good advice. After all, it is the major lung cancer risk remaining for nonsmokers.

Dr. Baker is incorrect in his assumption that this agency is ignoring other risks of cancer. In fact, Anne Arundel County initiated a comprehensive cancer prevention campaign in 1993 in response to a Johns Hopkins Needs and Resource Assessment that identified our high cancer mortality rates as being primarily related to behavioral factors. The Johns Hopkins study also suggested that we learn more about environmental factors, especially radon. We have done so.

The cancer prevention program at this department entitled "Learn to Live" was the recipient of a 1993 national award from the Academy for Health Services Marketing. Its focus is public education and the promotion of healthy lifestyles. It includes comprehensive tobacco use prevention, community smoking cessation clinics, self-help kits for smokers, and some unique programs aimed at reducing teen tobacco use. Additional components urge healthy diet and screening for breast and cervical cancer. Information and materials can be obtained by calling the "Learn to Live" line (410-222-7979).

To reach the community with these messages, we used a variety of marketing and health education techniques and enlisted the help of physicians, businesses, and community-based organizations and individuals. The program evaluation results have gained us national recognition. We have made numerous presentations to groups including students at The Johns Hopkins School of Hygiene and Public Health.

It is clear that tobacco use is the major factor in causing premature death and disability among residents of Anne Arundel County and the State of Maryland. I urge readers and Dr. Baker to support Smoke Free Maryland, a Coalition for Tobacco Control, which is a statewide effort with Med Chi as its nucleus. Information on the coalition can be obtained by calling Med Chi.

We are taking the liberty of adding Dr. Baker to our mailing list for "Learn to Live" materials. At this time, 700 physicians living or working in Anne Arundel County receive updates periodically. We have had very positive feedback and community support from those who are aware of our efforts. We expect that Dr. Baker will soon join them in supporting the Anne Arundel County Health Department's "Learn to Live" campaign.

KATHERINE P. FARRELL, M.D., M.P.H.
Deputy Health Officer, Anne Arundel County

LETTERS TO THE EDITOR

Dr. Baker replies

Many thanks to Dr. Farrell for her thoughtful letter on Anne Arundel County's cancer prevention activities. I have a question, however. Just how "cheaply" can radon levels be lowered? What are the maximum and minimum costs per home? My impression is that it is quite costly.

TIMOTHY BAKER, M.D., M.P.H.
Professor, The Johns Hopkins University School of Hygiene and Public Health

Cover stories

What is the story on the *MMJ* covers? Who is responsible for the selection? Some of the photography may be artsy, but what is the connection to medicine in this state? For instance, January 1995 shows an apartment building in Chicago. I just saw the same building in the movie *While You Were Sleeping*. What gives?

The April 1995 issue shows Maryland General Hospital as a pile of bricks and not new-looking bricks at that.

I'd just as soon see snapshots of somebody's grandchildren on the cover. I hope you folks at Med Chi have some sort of plan because I'll soon be removing *MMJ* from full view on my coffee table.

A.K. MUDGEON, M.D.
Towson, Maryland

Artwork chosen for MMJ covers is usually the result of a discussion among members of the Med Chi communications department. For issues in which most or all of the main articles deal with a single topic, we try to develop a cover related to that theme. Maryland General Hospital, a Baltimore City hospital with a long and venerable history, was featured on the April cover because all the main articles in that issue were written by physicians affiliated with Maryland General.

For issues not dedicated to a single topic, we have begun to choose artwork with a seasonal quality. Our graphic artist, Virginia Carter, is also an accomplished photographer and on several occasions we have relied on her ability to evoke a mood compatible with the cover month. Our January cover featured a photograph taken by Alan V. Abrams, M.D., which was the first-place color winner in Med Chi's 1994 photo contest.

We are sorry our recent covers seem unsuitable for your coffee table. However, if you know anyone with photogenic grandchildren, load your camera with film and enter your work in Med Chi's 1996 photo contest. We are always open to suggestions and we would welcome artwork submissions. Readers?

MARY ANN AYD
Managing editor

Catherine D. DeAngelis, M.D., and **Michael E. Johns, M.D.,** are the authors of an editorial/commentary in the *Journal of the American Medical Association* (1995;273:1056–1057) on the promotion of women in academic medicine. Dr. DeAngelis is the vice dean for academic affairs and faculty and Dr. Johns is dean of the medical faculty and vice president for medicine at The Johns Hopkins University School of Medicine.

Michele D. Wilson, M.D., and Alain Joffe, M.D., M.P.H., are the authors of an article indicating that violence, substance abuse, and the consequences of unprotected sex are the biggest problems facing American adolescents (*JAMA* 1995;273:1657–1659). Dr. Joffe is director of adolescent medicine and Dr. Wilson is a pediatrician at Johns Hopkins Children's Center.

Henry Silverman, M.D., of the division of pulmonary and critical care medicine at the University of Maryland Medical Center, is among the authors of a study describing the results of a multicenter clinical trial to investigate the efficacy and safety of monoclonal antibody to human tumor necrosis factor α in patients with sepsis syndrome (*JAMA* 1995;273:934–941).

Edward P. Shapiro, M.D., of the cardiology division of the Johns Hopkins Bayview Medical Center, and **Andrew P. Goldberg, M.D.,** of the division of gerontology at the University of Maryland Medical Center, are among the authors of a study indicating that older men with a long history of intensive endurance training demonstrate impaired early diastolic left ventricular filling performance similar to that of sedentary peers (*JAMA* 1995;273:1371–1375).

Stanley R. Hamilton, M.D., a professor of pathology and oncology at The Johns Hopkins University School of Medicine, is the lead author of a study identifying the genetic cause of Turcot's syndrome (*N Engl J Med 1995;* 332:839–847).

James M. Tielsch, Ph.D., a professor of international health at The Johns Hopkins University School of Hygiene and Public Health, is the lead author of a study indicating that blindness and visual impairment are highly prevalent among nursing home residents in the Baltimore area (*N Engl J Med* 1995;332:1205–1209).

Mary C. Corretti, M.D., Gary D. Plotnick, M.D., and **Robert A. Vogel, M.D.,** of the division of cardiology at the University of Maryland Medical Center, are the authors of a study published in the *American Journal of Cardiology* (1995;75:783–787) assessing brachial artery cold pressor, flow-mediated, and postnitroglycerin vasoactivity in men with and without coronary artery disease.

Rebecca Bascom, M.D., M.P.H., associate professor of medicine and director of the Environmental Research Facility at the University of Maryland Medical Center, is the lead researcher of a study indicating that portable air cleaners that filter out particles and the gases generated by tobacco smoke may reduce the severity of headache and nasal congestion in people who suffer symptoms from second-hand smoke. Results of the study were presented in May at the American Thoracic Society/American Lung Association International Conference in Seattle.

Samuel Charache, M.D., of The Johns Hopkins University School of Medicine, is the lead author for a multicenter study of the effect of hydroxyurea on the frequency of painful crises in sickle cell anemia (*N Engl J Med* 1995;332:1317–1322).

Joel E. Gallant, M.D., director of the Moore Clinic at The Johns Hopkins Hospital, is the lead author of a study indicating that chemoprophylaxis for *Pneumocystis carinii* pneumonia in people infected with HIV is associated with better outcome and use of fewer resources than in patients who do not receive preventive treatment (*Chest* 1995;107:1018–1023).

Oliver D. Schein, M.D., an associate professor of ophthalmology at the Wilmer Eye Institute, is the lead author of a study indicating there is little evidence to support the theory that a hole in the ozone layer over southern Chile caused an increase in ophthalmic or dermatologic diseases (*Am J Public Health* 1995;85:546–550).

Michael Mont, M.D., assistant professor of orthopedic surgery, and **David Hungerford, M.D.,** professor of orthopedic surgery at The Johns Hopkins University School of Medicine, presented at the annual meeting of the American Academy of Orthopedic Surgeons results of an 11-year study indicating that core decompression biopsy may avert the need for hip replacement in some patients.

Douglas P. Beall, M.D., a radiology resident at The Johns Hopkins Hospital, is co-author of an editorial on physicians' freedom to choose their specialty that was published in the resident physician's section of the *Journal of the American Medical Association* (1995;273: 1238a).

Gary D. Plotnick, M.D., Zenaida Feliciano, M.D., and **Andrew A. Ziskind, M.D.,** of the University of Maryland Medical Center, are coauthors of a study indicating that pulmonary hypertension decreases the predictive accuracy of echocardiographic clues for cardiac tamponade (*Chest* 1995;107:919–924).

David A. Sack, M.D., of the department of international health at The Johns Hopkins University School of Hygiene and Public Health, is among the coauthors of a report on a multicenter study by the U.S. Rotavirus Vaccine Efficacy Group. Results of the study were published in the *Journal of the American Medical Association* (1995;273:1191–1196).

Hugh A. Sampson, M.D., of the department of pediatrics and the division of immunology and allergy at The Johns Hopkins University School of Medicine, is among the authors of a study indicating that the measles vaccine can be safely administered in a single dose to children with even severe hypersensitivity to eggs (*N Engl J Med* 1995;332:1262–1266).

William T. Carpenter, Jr., M.D., and **Carol A. Tamminga, M.D.,** of the Maryland Psychiatric Research Center, are among the authors of a literature review indicating that the costs and adverse drug effects of clozapine can be minimized by careful patient selection and drug discontinuation if benefit is not observed within two to four months (*Am J Psychiatry* 1995;152:827–832).

Lawrence S. Wissow, M.D., M.P.H., of the departments of pediatrics and psychiatry at The Johns Hopkins University School of Medicine, is the author of a review article published in the *New England Journal of Medicine* (1995;332:1425–1431) on child abuse and neglect.

Eric K. Raowinsky, M.D., of the division of pharmacology and experimental therapeutics, and **Ross C. Donehower, M.D.,** of the division of medical oncology at The Johns Hopkins University School of Medicine, are the authors of a comprehensive review article on paclitaxel published in the *New England Journal of Medicine* (1995;332:1004–1014).

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Child health care in Charles County, Maryland: a needs assessment

Lee Muecke, M.D., M.P.H., Judith D. Rubin, M.D., M.P.H., and Marilyn S. Radke, M.D., M.P.H.

Dr. Muecke is a pediatrician at LBJ Hospital in Houston, Texas; Dr. Rubin is an associate professor of pediatrics and an associate professor of epidemiology and preventive medicine at the University of Maryland School of Medicine; and Dr. Radke is a former health officer for Charles County, Maryland.

ABSTRACT: *In response to the perception of community leaders in Charles County, Maryland, that more health care services should be available for disadvantaged infants and young children in the county, an informal needs assessment was carried out. First, available public health statistical data were used to estimate the number of children under 10 years of age residing in low-income households without health insurance. Next, a household survey and a physician survey were used to determine community and professional attitudes regarding unmet child health care needs, barriers to care, and possible solutions. Survey results validate the existence of unmet health care needs of county children as well as support for a volunteer clinic to address these needs.*

A substantial proportion of children in the United States receive inadequate medical care.[1] Some are from families that lack private insurance but whose family income is too high to qualify for full medical coverage by public assistance programs.[2] Although the phenomenon, sometimes referred to as "children of the working poor,"[3] exists throughout the country and has received attention from the public health community,[1,4,5] recent reports suggest that it might be a particular problem in Maryland.[5-7]

Charles County, Maryland, located 18 miles south of Washington, DC, has a population of just over 100,000.[8] The majority of the residents of this rural county are white (78%); the remainder are primarily African-American. Twenty-three percent of the population is under 20 years of age.

For several years, community members and public health officials had suspected that a significant number of children residing in Charles County were not receiving adequate ambulatory medical care, a concern supported by the observation that many children who presented to health department "well child" services were ill and required treatment rather than preventive services. In 1991, a local coalition was formed to support development of a new volunteer or grant-supported clinic for underserved children under age 11, the group felt to be most at risk and most in need of services. The University of Maryland Preventive Medicine Residency Program was asked to help gather data to determine the need for such a clinic.

Methods

Due to time and budget constraints, we chose to forego a formal needs assessment[9] and instead made estimates of the size of the underserved child population based on assumptions and existing information. We supplemented the quantitative estimates with two qualitative measures to characterize the community's perception of a need for better access to ambulatory care for children: a survey of low-income residents and a survey of area physicians.

A door-to-door opinion survey was conducted by local volunteers in neighborhoods identified by local public health officials as being economically depressed. The questionnaire included demographic information and questions about the availability and accessibility of health care for needy families in the county. The questions were intended to capture the target community's perceived health care needs and problems, as well as attitudes about future utilization of new child health services. Interviews lasted 15 to 90 minutes; longer interviews occurred when there were higher levels of distracting events in the home environment. Summary data were prepared and individual questionnaires destroyed to preserve the confidentiality of respondents.

Physicians attending a quarterly staff meeting at the community hospital in June 1991 were asked to complete a brief questionnaire about their experiences with uninsured children in their practices and about how best to provide services for such children in the future.

Results

Estimation of underserved child population. The target population included children who were "uninsured" or "unable to pay" for health care. Overall in Maryland, 17.6% of children are without health insurance.[10] County-specific statistics on the extent of health insurance coverage were not available. According to the case-formula method for determining funding for local health departments, however, Charles County falls in the middle range among Maryland counties. We therefore used the statewide figure to estimate the uninsured child population in the county. Census data indicated there were 17 910 children from birth to 10 years of age residing in Charles County in 1990. Using the statewide figure of 17.6% of uninsured children, we estimated that 3152 children in Charles County were without health insurance coverage.

Children were classified as "unable to pay" regardless of their insurance status if their annual "family household"[11] income was less than $15 000. The arbitrary cut-off included the bottom fifth (21.6%) of all household incomes in Charles County. Thus, approximately 3869 county children were classified as "unable to pay" for private health care.

Household interviews. Of the 349 people surveyed between June 1 and September 30, 1991, 91% were women. The major-

Table 1. Opinions of household respondents in Charles County, Maryland, (n = 349) about health care for needy families

Questionnaire item	Percent of respondents
Not enough health care for needy families and their children in Charles County	87
Know a lot of needy families in Charles County that do not get good health care	61
Know needy people in Charles County who never receive health care because they could not pay for it	80
Not easy to get places that provide health care for needy families in Charles County	78
Not good public transportation to places that provide health care for needy families in Charles County	56
Know needy people in Charles County who never receive health care because they have no way to get there to receive care	66
People in Charles County are interested in doing something about providing health care for needy families	69
Good idea to start a medical clinic to serve needy families in Charles County	91

ity of respondents (66%) were aged 30 or less; 21% were between 31 and 40 years of age and 13% were over 40. The largest groups were African-Americans (65%) and non-Hispanic whites (27%). Seventy-one percent were single, 22% married, and 7% separated or widowed. Household size was almost evenly distributed among households of 3 or fewer people (31%), 4 people (32%), and 5 or more people (38%). Consistent with the intention to oversample disadvantaged neighborhoods, most (73%) respondents reported an annual household income of less than $10,000.

Opinions of those surveyed are shown in **Table 1**. Respondents consistently expressed concern about lack of access to health care in Charles County. The majority believed there was not enough health care for low-income families and their children in Charles County and that those in need could not access existing care due to inability to pay for services. A majority felt that a new medical clinic should be started to serve needy families. Transportation was identified as a major barrier to receipt of health services. Most respondents (68%), however, preferred a clinic in a stationary building rather than in a mobile van or trailer.

Table 2. Responses of Charles County physicians (n = 29) to survey on child health care needs

Questionnaire item	Percent of respondents
Children who cannot pay for my services are *usually:*	
patients I have seen before	41
new patients	45
patients who previously had insurance coverage but who have none now	38
patients who have never had insurance coverage	35
eligible for Medicaid but have not applied	24
probably not eligible for Medicaid	55
a financial burden to my practice	35
not a financial burden	55
Unmet health care needs for uninsured children in Charles County include:	
inpatient/hospital care	28
ambulatory/"sick" care	62
preventive/"well" care	62
Physician services for uninsured children in Charles County can best be provided by:	
health department physicians	83
private practice physicians	40
volunteer physicians	41

Respondents were asked whether they knew anyone in the past year who had not received medical attention for various health problems. The largest proportion of affirmative answers (64%) was for dental problems; in addition, more than half the respondents knew someone who had not received treatment for cardiovascular disease, for respiratory problems, and for gastrointestinal ailments. Sixty-three percent knew someone who had gone to an emergency room for medical treatment during the past year.

Physician survey. Of the 65 physicians listed as active members of the Charles County Medical Society, 40 completed the physician questionnaire. About half the respondents were primary care physicians (6 family/general practice physicians, 8 internists, and 2 pediatricians); the remainder were surgeons (n = 5) and other specialists. Twenty-nine (73%) reported caring for children; of these, 21 (72%) reported that one-quarter or less of their practice comprised children.

Opinions of the 29 physicians whose patients included children are shown in **Table 2**. Most had seen children who could not pay for services rendered, but only one reported that this had happened frequently. About equal proportions of physicians identified patients who were unable to pay as previous patients and as new patients. Nearly equal numbers of physicians perceived nonpaying patients as having been previously insured and as having never been insured; about half thought the children may have been eligible for Medicaid, but had not applied. Ten physicians said the children who were unable to pay were a financial burden to their practice. Although almost all respondents identified health department physicians as the ideal source of care for uninsured children in Charles County, approximately half suggested the use of volunteer physicians.

Discussion

A combination of methods provided an expedient and inexpensive characterization of a medium-sized county's

need for child health care services. We estimate that approximately 3500 uninsured and/or low-income children under age 11 in Charles County are unable to afford adequate health care.

The physician survey indicated that many children are being seen without insurance coverage and are perceived by some practitioners as a burden to their practices. In household interviews targeted to low-income neighborhoods, the majority of respondents expressed a need for additional child health care services and felt that establishment of a new clinic could meet the need. Community opinion regarding potential utilization of a new clinic was felt to be an important variable in our needs assessment because previous research has demonstrated that consulting the community regarding design of and planning for expansion of health care services is essential to the ultimate success of implementation.[5]

An important finding was the lack of adequate transportation to existing health care facilities. Charles County does not have a local public bus system, so low-cost public transportation is not readily available. Both new and existing health care facilities should recognize the limited accessibility to services and future planning should include solutions to the transportation problem for low-income county residents.

The situation in Charles County is not unique; inadequate health care for children is part of a national dilemma. An estimated 10 million children in the United States are without health insurance and receive little or no health care.[1] Among the many contributing factors are inadequate political representation,[1] racism, classism,[5] and lack of funding.[1] Nationally, 15 times more money is spent on the health care of the elderly than on the health care of children.[12] Although half the Medicaid population comprises children, children receive less than 20% of Medicaid funds expended.[12] Reimbursement levels from Medicaid are so low that some physicians in private practice are unwilling to see children who have only Medicaid coverage,[12] and many physicians provide treatment without adequate reimbursement.

Because children of the "working poor" generally do not meet criteria for traditional public assistance programs, they present a special challenge to child advocates. Across the nation, many communities have successfully assembled local coalitions to develop creative solutions to the problem of inadequate health care services for children.[5] The American Academy of Pediatrics offers technical assistance to communities attempting to solve local health care insufficiencies by using a variety of resources.[13] In New York City, the initiative for a project called Agenda for Children Tomorrow (ACT) came from the private sector, which began the effort to address local child health care needs with baseline documentation of service needs and patterns of use and subsequently received support from the city and other sources.

Such approaches require skill in drawing together available resources and recruiting additional resources where deficits are identified. The affirmative response of the providers in the current survey supporting volunteer physician manpower is encouraging. Both health care recipients and providers must play active roles in the planning and implementation of community-based efforts to augment availability of local health care services.

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Acknowledgment

This project could not have been completed without the supervision of Sister Michaeleen and the Sisters of Mary's Song, along with volunteers from Charles County, Maryland. We are indebted to these individuals for their persistence and effectiveness in meeting the needs of their community. ■

Patient education: the risks associated with radiation exposure

Fishel Z. Liberman, M.D., Ph.D., and Hubert A. Eddy, Ph.D.

From the department of radiation oncology at the University of Maryland School of Medicine, where Dr. Liberman is an assistant professor and Dr. Eddy is director of radiation research.

In a society that has grown ever more conscious of safety and the environment, the hazards from radiation exposure, particularly from medically related sources, are of growing concern. In a medical world where physicians order an increasing number of x-rays, computed tomography (CT) scans, and mammograms, it is important to be able to discuss with patients the relative risks and benefits from low-level radiation exposure and to compare them with other risks commonly encountered in day-to-day living.

X-rays were discovered by Dr. Wilhelm Roentgen in 1895. Three years later, Henri Becquerel discovered radioactivity and Madame Curie discovered radium.[1,2] Shortly after these discoveries, x-rays were first used in nonmedical applications, such as depilatories for the axillary region. Several bilateral amputations later, it became evident that this new-found modality had a dangerous aspect. The first death attributed to radiation in the United States occurred in 1906.[3]

In more recent times, it has been shown that radiation exposure can cause human cancers, affecting, for example, the skin, lung, bone, thyroid, and breast.[4-8] Leukemia and childhood malignancies also have been associated with radiation exposure.[9,10] Clinical documentation for all these types of cancer exists. Additional data have come from the atomic bomb experience at Hiroshima and Nagasaki,[10-12] and more recently from the nuclear accident at Chernobyl. Most of these cases involved considerably higher exposure than would be used in a controlled medical setting. Two particularly germane examples are the increased incidence of breast cancer in patients who underwent hundreds of fluoroscopies in tuberculosis sanitariums in Scandinavia and Canada;[13,14] and the increase in leukemia and solid tumor cancer rates among survivors of the atomic bombs dropped over Japan. No increase in birth defects or malignancy in children born after prenatal exposure was noted.[10,15] As

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Table 1. Organ dose received for various radiologic procedures

Procedure	Dose (mrad) to		
	Marrow	Lung	Breast
Chest radiograph	4	20	14
Cervical spine	10	15	-
Upper GI	120	500	55
Cholecystogram	65	180	-
Intravenous pyelogram	120	35	-
Mammogram	-	-	100-250

Source: Committee on Radiological Units, Standards, and Protection. *Medical Radiation: A Guide to Good Practice*. Chicago, IL: American College of Radiology; 1985.

these examples show, it is certainly possible to induce malignancies with radiation, either iatrogenically or as a result of war.

Many people are aware of these events and possibilities and, as patients, become concerned that routine radiologic tests actually may induce the cancer for which they are being screened. Patients often ask how much radiation they are receiving and how much radiation is safe. To answer these questions, an introductory understanding of the units of radiation physics is needed.

How radiation exposure is measured

Radiation exposure in air is measured in units of roentgen (R). Absorbed dose in any tissue is measured in rad or gray (Gy), with 100 rad = 1 Gy. To account for different tissue absorptions, a multiplicative coefficient (or weighting factor) is used to convert rad to rem (1 rad is approximately equal to 1 rem).

There has been a recent change to standard international units of Sievert: 100 rem = 1 Sievert, or 1 mrem = 0.01 mSievert. **Table 1** provides estimates of normal exposures for various radiologic procedures. A chest x-ray gives from 2 to 20 mrem per exposure;[16] a mammogram gives approximately 100 to 250 mrem per view.[17] Thus, for example, a woman who undergoes a screening mammogram at age 35, every-other-year mammograms from ages 40 to 50, and then yearly mammograms until age 65 would receive a total of 11 rem to her breasts. Compared with the 100 to 500 rem received by patients in the tuberculosis sanitariums, there is a difference of at least one order of magnitude.

Having ascertained how much dosage is administered per procedure, the next question is how much radiation can be given safely without causing undesirable effects. In theory, there may not be a minimum safe dose.[16,18,19] Multiple radiobiologic models have been used in attempts to explain radiation cell killing or carcinogenesis as a function of dose.[18,20] It is unfortunate that in the very-low-dose region, it is possible to fit almost any model to the data.

An alternate way to look at the problem is to determine whether variations in naturally occurring background radiation from one locality to another have any correlation with cancer rates.

Background doses

On the east coast, an individual receives an average background dose of 60 to 90 mrem/year (0.090 rem/year). In Denver, Colorado, the background rate is 160 to 180 mrem/year. However, there are certain places where background radiation rates are much higher. One sixth of the population of France receives between 180 and 360 mrem/year; in Brazil, the average annual background dose is 500 mrem; and in parts of the Madras region of India, the exposure is 1300 mrem/year. Despite generations of exposure, in none of these places has an increased rate of mutation, cancer, or death been noted.[21]

Alternatively, radiation exposure effects can be inferred from either genetic, carcinogenic, or somatic changes. It also may be possible to glean information about radiation exposure from occupational radiation exposure records.

Genetic effects

A great deal of uncertainty exists in estimating the genetic hazards of radiation exposure in humans. Direct evidence is scanty and extrapolation must be made from animal studies. Gene mutations and chromosome aberrations have been documented after irradiation, one measure of which is the doubling dose (the radiation dose required to produce a mutation rate equal to the naturally occurring rate). Studies of the children of survivors of Hiroshima and Nagasaki indicate that the doubling dose was approximately 156 rem.[22] The BEIR III committee estimated the doubling dose from animal data to be between 50 and 250 rem.[16] An individual receives approximately 3 rem from natural background sources during his or her reproductive lifetime. The Hiroshima and Nagasaki data reveal no increased incidence of prenatal or neonatal malformations in patients exposed to about 100 rem.[23]

Carcinogenesis

Carcinogenic effects of radiation may take as long as 20 to 30 years to manifest. The type of cancer that develops depends on the area originally treated or exposed, as well as

Table 2. Time to cancer development after radiation exposure

Site	Years
Thyroid	20
Bladder	21
Skin	25
Breast	23

Source: UNSCEAR. *Sources and Effects of Ionizing Radiation*. New York, NY: United Nations Scientific Committee on the Effect of Atomic Radiation; 1977.

other variables (**Table 2**). In terms of radiosensitivity, the thyroid gland requires a very small dose, as low as 2 rem, for carcinogenesis to possibly occur.[24] Young women are the group most at risk, and the average delay between exposure and development of thyroid malignancy is 15 to 25 years. Numerous cancers can be radiation induced, and one can well understand the concept of keeping radiation exposure to a minimum.

Somatic changes

Somatic noncancerous changes also can occur. The most feared is radiation to pregnant women causing fetal changes. The most frequent is cataract formation.

Our knowledge of the radiation effects on the fetus is based on data from accidental exposures, war actions, and extrapolation from animal experimentation.[25-27] Moderately large doses of radiation (>250 rad) delivered to the human embryo before 2 to 3 weeks of gestation are not very likely to produce severe abnormalities, although there may be a considerable amount of fetal wastage. Irradiation between 4 and 11 weeks' gestation would probably lead to severe abnormalities of many organs in most children (not proven). When the fetus is irradiated between weeks 8 and 20, the most significant effect is cerebral atrophy. Irradiation between weeks 11 and 16 may produce eye, skeletal, and genital organ abnormalities; stunted growth, microcephaly, and mental retardation frequently occur. Between 16 and 20 weeks of gestation, irradiation may lead to a mild degree of microcephaly, mental retardation, and stunting of growth. Irradiation after 30 weeks of gestation is not likely to produce structural abnormalities, but could lead to functional disabilities.

Whether prenatal exposure to diagnostic x-rays increases the risk of childhood malignancy is unknown. In the atomic bomb experience, no increase in induced childhood malignancies was noted.[10] Data from MacMahon[28] in New England, however, indicated a 50% increase in these malignancies after x-ray exposure.

The current national recommendations for radiation exposure during pregnancy are that a woman get as little radiation as possible. Up to 500 mrem during pregnancy is permissible, but if a woman receives more than 10 rem (10,000 mrem), she should consider an abortion.[29] The dose between 501 mrem and 9,999 mrem is a gray zone wherein recommendations must be individualized.

Radiation-induced cataracts can form after as little as 600 rem to the lens. The condition has a variable latency between 6 months and 25 years, the shorter time period usually being associated with a higher dose.[30,31] With the advent of effective cataract surgery, the problem has become a relatively minor concern to patients receiving therapeutic radiotherapy.

Occupational exposure

Data for occupational exposure come mostly from those who worked for the Radiological Society of North America between 1935 and 1958. Although 7.7 deaths were expected, 19 occurred. As a result, in 1958 the National Committee on Radiation Protection (NCRP) defined the "Maximum Permissible Dose (MPD) for radiation health workers to be 5 rem/year." Updates of NCRP recommendations through 1988[32] include the following:

For all personnel, the underlying principle for radiation exposure should be As Low As Reasonably Achievable (ALARA).

- For occupational exposure:
  - Maximum permissible dose (MPD) is 5 rem/year.
  - The lens of the eye may receive up to 15 rem/year.
  - Various organ sites such as skin and extremities may receive up to 50 rem/year.
- For non-radiation workers:
  - Nonmedical exposure should be limited to 0.1 rem/year.
  - A pregnant woman should not receive more than 0.5 rem during the course of her pregnancy. Once it is established that an individual is pregnant, dose should be limited to 0.05 rem/month.

All those who work with or near radioactive materials or x-rays should wear a film badge, with the printed side out. Issued monthly, the badges can measure a minimum dose of 10 mrem. In most instances, a radiation health care worker receives less than the minimum 10 mrem reading per month. For those routinely exposed to higher doses of radiation, pocket dosimeters, which instantaneously measure dose received, are available.

Relative risks

It is clear that all radiation is potentially dangerous. A more reasonable and answerable question is, "to what risk am I exposed in getting a mammogram, a chest x-ray, a bone scan?" Probably the best way to answer is to compare the risk of death from radiation exposure to more mundane risks of death that many people take daily (e.g., driving or smoking). Although the comparisons are far from precise, one can estimate how many traffic fatalities occur yearly, approximately how many miles are driven annually, and thus the chance of traffic fatality per mile driven. A similar analysis for the chance of fatality per cigarette smoked can be calculated.[33] Comparing these calculations to the previously obtained radiation safety data allows the comparisons shown in **Table 3**. Thus, the risk from a chest x-ray is equivalent to that of driving 21 miles or smoking 7 cigarettes. Patients who otherwise would refuse screening examinations often accept the prescribed procedure when they realize that the risk they are taking may be comparable to the risk from their ride home.

Conclusion

Radiation exposure has been shown to cause genetic, carcinogenic, somatic, and fetal changes. Because there does not appear to be an absolutely safe lower threshhold for radiation exposure, the standard for radiation safety is as low as reasonably achievable. When diagnostic or therapeutic radiation exposure is medically indicated, the benefits certainly seem to far outweigh the minuscule risks incurred.

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Table 3. Risk of death associated with radiation, smoking, and driving

Procedure	Dose (mrem) (Bone Marrow)	Chance of Death (From Leukemia)	No. of Cigarettes*	No. of Highway Miles**
Chest radiograph	10	2×10^{-7}	1.5	3.6
Skull exam	78	1.6×10^{-6}	11.4	28
Barium enema	875	17.5×10^{-6}	128	313
Mammogram	0	N/A***	N/A	N/A

* Chance of death from having smoked the number of cigarettes.
** Chance of death from having driven the number of miles
*** No bone marrow exposure.

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According to a report released by the Physician Insurers Association of America (PIAA)* Data Sharing Project, results of a study that tracked 125 000 claims and suits filed since 1985 show that breast cancer (and especially a delay in its diagnosis) accounts for more medical malpractice claims and suits than any other single condition. Radiologists (24%) and obstetricians (23%) were the most frequently named defendants, followed by family practitioners (17%), surgeons (14%), internists (9%), other specialists (5%), corporations (4%), pathologists (2%), and hospitals (2%). PIAA recommends that all practitioners involved in the diagnosis of breast cancer

- document all patient complaints relative to the breast;
- document any family history of breast cancer;
- document the results of any previous mammographic studies;
- document the recommendations for subsequent diagnostic studies and follow-up;
- follow up with other physician consultants regarding test results, etc.;
- always do a tissue diagnosis when there is a palpable mass and negative mammogram;
- not delay appropriate diagnostic studies because of pregnancy.

* PIAA is an association of 50 medical malpractice insurance companies owned or controlled by physicians or dentists and 4 reinsurance companies.

Pertinent medical intelligence: fluoxetine's impact on sexual function

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It is well established that drugs which selectively enhance central nervous system synaptic serotonin may affect sexual function in animals and humans. Fluoxetine (Prozac) is one of these medicines. Because of its antidepressant, antianxiety, and antiobsessional properties, fluoxetine is now one of the most frequently prescribed drugs in the world. Millions of patients have been treated with it since it was marketed in 1988.

Such extensive usage of fluoxetine has produced data indicating that about 8% of fluoxetine-treated men and women develop fluoxetine-induced sexual dysfunction, including diminished libido, erectile dysfunction, delayed or inhibited ejaculation, and anorgasmia.[1] The true incidence of the sexual side effects of fluoxetine, however, may be higher for two reasons. First, many physicians do not ask about the impact of prescribed medicines on their patients' sexual functions; and second, many patients, especially women, are embarrassed by sexual dysfunction and do not spontaneously report it to their doctor, particularly if the physician is a man. In addition, some patients erroneously attribute changes in sexual desire and performance to causes other than medication. In fact, some physicians attribute changes in libido and erectile capacity not to fluoxetine, but to the patient's depression, which is not always correct.

Fluoxetine-induced sexual dysfunction may affect significantly patient comfort and treatment compliance. Orgasmic and erectile difficulties and altered sexual drive usually occur within the first two months of fluoxetine therapy and persist as long as the causative dose of fluoxetine is taken. These sexual side effects tend to diminish with dose reduction, but it may take three to four weeks after fluoxetine discontinuation for their full remission to occur.

The occurrence of sexual dysfunction during fluoxetine therapy may not be due to the drug, but to undertreatment of the patient's depression (a not uncommon phenomenon) or to a lack of response to fluoxetine.

Therefore, a careful evaluation of the patient's sexual function prior to and during fluoxetine therapy is warranted. This will help the physician select from a variety of treatment options for the sexual dysfunction, ranging from dose reduction, dose increase, continuance of the currently prescribed fluoxetine dose (to avert premature dosage reduction or discontinuation), or coprescription of amantadine,[2] bupropion (Wellbutrin),[3-4] cyproheptadine (Periactin),[5] or yohimbine (Yocon),[6] any of which may produce partial or complete relief of fluoxetine's sexual side effects, often within the first treatment week.

To date, there has been a single case report of priapism associated with fluoxetine.[7]

Fluoxetine's effects on sexual function may be used to treat two distressing and common sex disorders: premature ejaculation and paraphilias. As noted above, fluoxetine frequently delays ejaculation.[6,8,9] This pharmacologic effect can be responsible for a remarkable improvement in premature ejaculation that continues as long as the effective dose of fluoxetine is taken, often without causing more than minor side effects, which usually are outweighed by the substantial improvement in the patient's quality of life.

Experts who have treated paraphiliacs experimentally with fluoxetine also have found it safe and beneficial for some of these individuals, whose quality of life has been improved substantially by fluoxetine therapy (40-60 mg/day).[10] This is mentioned here solely for the information of physicians who may be asked for help by a paraphiliac. These men should be referred to a specialist for evaluation for fluoxetine therapy.

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PETRUS JULIANI, M.D., LATER POPE JOHN XXI

Throughout its history, Christianity has fostered charity; as a result schools, hospices, and hospitals were often built around monasteries. When care of the sick was needed in these areas, it often was provided by monks and nuns. Medical men in some of the early European universities were all clerics and although some medically trained ecclesiastics succeeded to high office in the Church, only one ever became pope.[1]

Petrus Juliani, or Petrus Hispanus, born in Lisbon (ca. 1210-1220),[2] was the son of a physician and thus was afforded the opportunity to study at the University of Paris. One of his teachers was Albertus Magnus,[3,4] who, with the possible exception of Roger Bacon, was arguably the most learned man of his time in science, philosophy, and theology. Studying Aristotelian physics, metaphysics, medicine, theology, and the arts, Petrus received his master's degree in 1240. In 1247, he became professor of medicine at the newly created University of Siena. He wrote extensively in the field of medicine, as well as commentaries on the writings of the ancient Greek physicians. He was interested in the eye and published a book, *Liber de Oculo,* about its anatomy, diseases, and treatment (a German translation is available[5]).

Petrus' advancement in the Church paralleled his medical progress. In 1250, he became dean of the cathedral in Lisbon and archdeacon of Braza. In 1273, he was consecrated a bishop. He was appointed Cardinal Archbishop of Tusculum, but continued to govern the See of Braza until 1275, when, having been chosen the 186th pope, he took the name John XXI. More to be remembered as a philosopher and scientist than as a pope, John XXI still found time for his scientific studies amid the cares of the papacy. To secure a place for his studies, he had an apartment added to the papal palace at Viterbo. On May 14, 1277, when he was alone in his study, the building collapsed. He died two days later.

JOSEPH M. MILLER, M.D.

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Case report: peritonitis complicating cone biopsy of the cervix

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Cone biopsy of the cervix, an established part of gynecology practice for many decades, is a generally safe procedure. We report a patient who developed peritonitis after cone biopsy.

Case report

A 43-year-old woman, gravida one, para one, had a class III pap test November 2, 1990. Her uterus was normal in size, shape, and consistency and minimally anteflexed. She was using no contraception or steroids and had no chronic illness.

On January 15, 1991, a colposcopy and endocervical biopsy showed punctation and mosaicism at 12 o'clock extending into the endocervical canal. Cervical biopsy revealed CIN I changes consistent with the colposcopy. The endocervical biopsy revealed atypical squamous metaplasia. Because of these findings an outpatient cone biopsy of the cervix was performed on February 9, 1991, without incident.

The cervix was injected at 3 o'clock with 8 units of pitressin in a dilute solution (20 units/200 ml normal saline). Single O chromic sutures were then placed laterally. The cervix was sounded, the base of the cone sharply circumscribed with a scalpel, and the cone apex was divided with Mayo scissors. Two figure-of-eight sutures were then placed in the cone bed.

Three days after conization, the patient experienced the onset of general malaise and mild lower abdominal pain, with chills that evening. On the next day, she had progressively worsening abdominal pain with tenderness, guarding and rebound, temperature of 103°, and chills. Results of a urinalysis were normal (3 to 5 white blood cells and negative nitrites); culture grew less than 10,000 skin contaminants. The white blood cell count was 17,200 (12% bands and 80% segments). The patient was admitted to the hospital.

An exploratory laparotomy was done because of concern regarding the possibility of perforation. The abdomen was entered through a small midline incision, carried down with sharp dissection until the peritoneal cavity was entered. A retractor was placed and the pelvic organs were studied. The uterus appeared normal in size and firm in consistency, and there was no evidence of perforation. The tubes and ovaries were also normal bilaterally except for an unruptured corpus luteal cyst of the left ovary. The bowel was run, and there was no evidence of a perforation in the small or large bowels. The appendix was normal. The pelvic cavity was then irrigated with warm saline and the instruments and bowel packs removed. The peritoneum was then closed, followed by closure of the fascia with #0 prolene. Subcutaneous stitch was used, followed by staples on the skin. A sterile dressing was placed over the incision. A speculum was then placed in the vagina. A single-tooth tenaculum was used to grasp the anterior lip of the cervix and the cervical canal was probed and dilated with a Bozeman forceps. Cultures were obtained, after which the patient was transported to the recovery room in stable condition.

A blood culture done preoperatively grew *Escherichia coli*, and culture of peritoneal fluid and the cervix also showed *E.coli* with the same sensitivity pattern. The patient was treated with intravenous Unasyn and gentamicin, had prompt defervesence, and was discharged on the fifth hospital day to continue oral ciprofloxacin twice daily for three more days.

Discussion

A number of studies have reviewed complications that may follow cone biopsy,[1-4] and case reports have described specific complications, including neuroma,[5] hematocervix and hematometria,[6] cervical stenosis,[7] cervical endometriosis, and tubo-endometrioid metaplasia.[8]

In one study,[1] the incidence of fever was 2 in 100 cases; in another,[2] it was 3.3%. Of 1008 patients who underwent cone biopsy procedures, 3 developed abscess and 1 developed "pelvic cellulitis" with intestinal obstruction; for the others, although fever exceeded 104°, height was not specified.

Seshardri and colleagues[5] reported a "pelvic infection rate of 0.6%," but gave no other details. And Jones and Bueller[4] reported one patient who developed pelvic infection and sepsis with disseminated intravascular coagulation and acute tubular necrosis.

Although a number of reports have mentioned pelvic infection, the current case appears to be the first reported instance of pure peritonitis following surgery. The mechanism of infection may have been migration of bacteria through transected blood vessels or lymphatic channels with seeding of the peritoneum. Isolated peritonitis should be included in the differential diagnosis of symptoms of peritoneal inflammation following cone biopsy of the cervix.

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The World Health Organization Global Program on AIDS predicts that in 1995, up to 6.5 million women worldwide will be HIV-positive. In Africa, women now account for 55% of all new HIV cases. WHO data indicate the 1995 worldwide distribution of HIV-infected women will be:

◗ Australasia:	5000
◗ Eastern Europe and Central Asia:	8000
◗ North Africa and Middle East:	25 000
◗ East Asia and Pacific:	40 000
◗ Western Europe:	75 000
◗ North America:	115 000
◗ Latin America and Caribbean:	425 000
◗ South and Southeast Asia:	1 750 000
◗ Sub-Saharan Africa:	4 000 000



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Cerebrovascular disease is the third leading cause of death in the United States based on total number of deaths. In addition, there are three million stroke survivors each year. The annual cost of stroke in the United States is estimated in billions of dollars, including the cost of medications, physician and nursing services, and lost productivity. It is not surprising that the largest proportion of the cost is in hospital and nursing home care. The disability and loss of independence that result from stroke are also costly in human terms.

The incidence of stroke increases with increasing age. As the population at greatest risk for stroke increases, there will be an increase in the utilization of long-term care facilities for stroke survivors. Based on 1985 data demonstrating that 20% of nursing home residents carried the diagnosis of cerebrovascular disease and the projected increase in the elderly population, it can be conservatively estimated that, by the year 2030, there will be more than 650,000 nursing home residents with cerebrovascular disease.[1] Safe and effective preventive measures for stroke have been validated by clinical trials.[2-8] Reducing the cost of stroke by preventive measures could have an important effect on the health care system.

Risk factors

There are a number of risk factors for stroke that, if recognized, can be modified, thereby decreasing the risk of a future stroke. The well-established risk factors for stroke include hypertension, cigarette smoking, alcohol consumption, and atrial fibrillation. Other risk factors include coronary artery disease, hyperlipidemia, diabetes mellitus, and congestive heart failure.

Hypertension. Approximately 50% of those over age 65 have elevated blood pressure (systolic blood pressure > 140 mm Hg or diastolic blood pressure > 90 mm Hg). Systolic hypertension is a particular problem in the elderly. The association of hypertension, both systolic and diastolic, and stroke is well established. Multiple studies have demonstrated a consistent decrease in the relative risk of stroke in treated individuals versus untreated controls. It is estimated that 70% of strokes could be eliminated with the treatment of hypertension.[2]

The recommendation of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure is that hypertension be treated to a level of 140/90 mm Hg.[9] In the elderly, drugs used to reach this level of blood pressure control should be used with caution. Rapid lowering of the blood pressure should be avoided, especially in those with atherosclerotic disease because it may trigger a decrease in the cerebral perfusion and may result in a stroke.

Smoking. There is little controversy surrounding the advisability of abstinence from cigarette smoking. Observational studies have demonstrated a dramatic reduction in stroke risk after a two- to five-year period of abstinence from smoking.[10]

Vascular disease. Patients who have had a transient ischemic event (TIA) have a 12% risk of a stroke within 1 year and a 35% risk of stroke or fatal event within 5 years. Aspirin is the drug of first choice for patients with a history of cerebral ischemia of an apparent noncardiac origin. In patients with allergy, intolerance, or failure on aspirin therapy, ticlopidine (Ticlid) is recommended.[3]

Patients with symptomatic carotid bruits and at least 70% luminal narrowing as determined by arteriography have significantly improved survival with carotid endarterectomy compared with medical management.[4] Recent data suggest that carotid endarterectomy in patients with asymptomatic carotid stenosis is preferable to medical management.[5,11] In these studies, carotid endarterectomy reduced the risk of future stroke in those with luminal narrowing of 50% to 60% who were good candidates for elective surgery.

Heart disease. Patients with a prior history of myocardial infarction have an increased risk of future stroke that can be reduced with the use of warfarin (Coumadin).[6] Aspirin is an alternative therapy, although the benefits with regard to stroke prevention are not as great.[12]

Atrial fibrillation is the most common supraventricular tachycardia and is a condition that increases in incidence with increasing age. Up to 5% of individuals over age 65 have atrial fibrillation. Most patients with atrial fibrillation have underlying cardiac disease including hypertension, ischemic cardiovascular disease, cardiomyopathy, and rheumatic heart disease.

The presence of atrial fibrillation also increases the likelihood of cardioembolic phenomena. Studies from the 1970s clearly demonstrated the increased risk for stroke and other embolic diseases in those with atrial fibrillation. Atrial fibrillation may account for 75 000 strokes per year in the United States. Five recent studies have shown a dramatic reduction in the risk for future stroke when those with both valvular and nonvalvular atrial fibrillation are anticoagulated. Analysis of the pooled data from the five studies further verified that warfarin reduces stroke risk in patients with atrial fibrillation without increased risk of major bleeding.[7]

There is widespread agreement that patients with atrial fibrillation and one of the following risk factors would benefit from anticoagulation with warfarin: age over 65, hypertension, previous TIA or stroke, congestive heart failure, and ischemic cardiovascular disease. Contraindications to anticoagulation with warfarin include recent gastrointestinal bleeding, high risk of falling, and possible noncompliance. In such individuals, aspirin may be substituted. Age alone does not preclude the use of anticoagulation. Older patients do indeed have a higher risk for hemorrhagic complications, but also have the most to gain from anticoagulation.

The international normalized ratio (INR) should be used to monitor levels of anticoagulation. Hemorrhagic complications can be minimized by close monitoring of the INR and adhering to the recommendations of the American College of Chest Physicians.[8] For the majority of patients, an INR of 2.0 to 3.0 achieves optimal levels of protection.

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Imaging Case of the Month

Spontaneous Adrenal Hemorrhage

A 46-year-old while man developed epigastric and periumbilical pain radiating to the right lower quadrant. An abdominal computed tomography (CT) scan performed on admission showed mesenteric stranding in the pericecal area suggestive of an inflammatory process. Images of the upper abdomen showed no abnormalities of the adrenal glands (**Figure 1**). Surgical exploration revealed acute suppurative appendicitis and an uncomplicated appendectomy was performed.

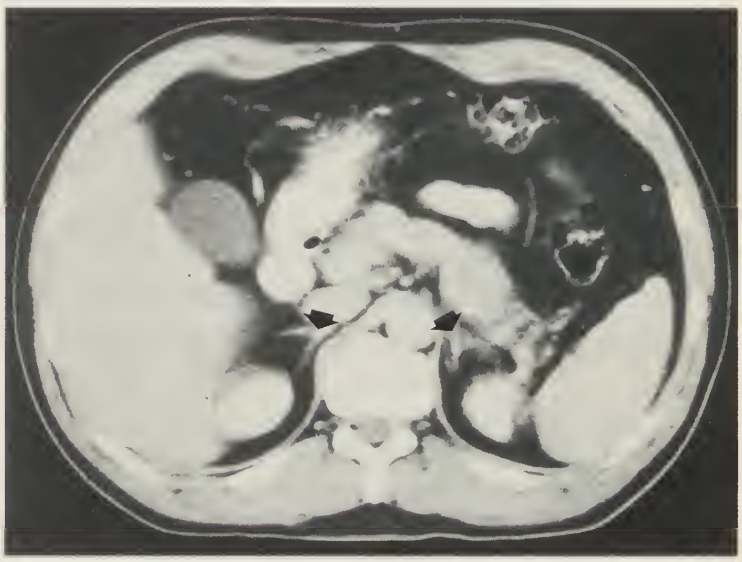


Figure 1. Image of the upper abdomen showing apparently normal adrenal glands.

The patient was discharged from the hospital on the fifth postoperative day. He did well at home for several days, but then developed shortness of breath, shifting abdominal pain, and pleuritic chest pain. On readmission to the hospital, a VQ (ventilation to perfusion) lung scan showed no evidence of pulmonary embolism. A repeat abdominal CT scan performed nine days after the initial scan showed enlargement of both adrenal glands. A 2 cm right adrenal mass was present, and the left adrenal gland appeared distinctly thicker than on the preoperative scan (**Figure 2**). The density of the right adrenal mass was most consistent with recent hemorrhage. Follow-up magnetic resonance (MR) scans showed symmetric bilateral adrenal masses with signal characteristics consistent with bilateral hemorrhage. The patient did well clinically, although he was noted to have a mildly lowered serum sodium concentration on a follow-up office visit.

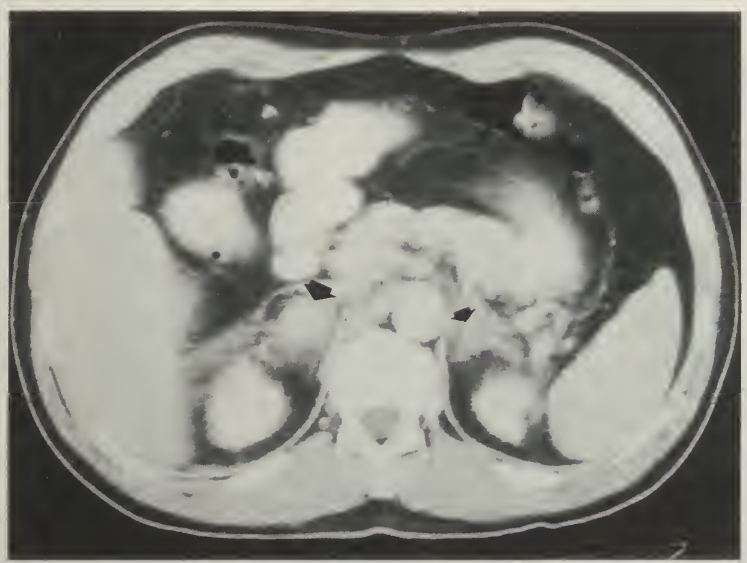


Figure 2. Abdominal CT scan performed nine days after the initial scan shows enlargement of both adrenal glands.

Discussion

Spontaneous adrenal hemorrhage is an uncommon condition that occurs in association with stress such as sepsis, hypotension, burns, or postoperative states.[1] Stress apparently subjects the adrenal cortex to stimulation by endogenous adrenocorticotropic hormone (ACTH),[2] producing a dramatic rise in adrenal blood flow with possible associated focal necrosis.[3] Another predisposing factor for adrenal hemorrhage is anticoagulant therapy[4] or hemorrhagic diathesis.

Before the development of CT scanning, the diagnosis of adrenal hemorrhage was frequently made only at postmortem examination. Its signs and symptoms are nonspecific (e.g., abdominal pain, hypotension, vomiting, weakness, and fever).[5] When it occurs in the postoperative period, intra-abdominal sepsis or pulmonary embolism is often suspected. Laboratory results may or may not suggest adrenal insufficiency with its typical findings of hyponatremia, hyperkalemia, and volume contraction.

CT scanning generally shows bilateral adrenal masses that may contain hyperdense areas secondary to recent hemorrhage.[3] Metastatic tumor, the most common cause of bilateral adrenal masses, is generally of lower density and less commonly produces adrenal insufficiency.

Once spontaneous adrenal hemorrhage is suspected, adrenal function can be evaluated with a corticotropin stimulation test. Failure of the adrenal glands to respond to exogenous ACTH stimulation is diagnostic of Addison's disease.[4] Early steroid administration can avert an acute adrenal crisis and can be truly lifesaving. Some patients with massive bilateral adrenal hemorrhage develop eventual adrenal atrophy with irreversible loss of adrenal function.[4] Others may recover completely.

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KEY ANSWERS

Rural hospitals frequently have only small medical libraries, volunteer staff, and limited financial resources. A recent National Library of Medicine program enabled three librarians from the Delaware Academy of Medicine in Wilmington to travel throughout the state teaching the basics of Grateful Med software to health care professionals, including 76 physicians. After attending the training program, Robert C. Ferber, M.D., senior staff member of Nanticoke Memorial Hospital in Seaford, Delaware (population, 5000), used Grateful Med to research treatment options for two AIDS patients. In one case, he retrieved an important article from the department of surgery at the medical school in Lusaka, Zambia. In the other, he obtained vital treatment information in a report from St. Josef Hospital in Bochum, Germany. In both cases, the information he obtained online resulted in his patients' clinical improvement.

Source: *Gratefully Yours,* March/April 1995. Bethesda, MD: National Library of Medicine.

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Maryland physicians who helped make medical history: a portrait of Eugene H. Guthrie, M.D.

In our busy, stressed lives, we often take for granted much of the medical progress that has occurred, forgetting how much some of our colleagues have contributed to our happiness, health, and longevity. Following is the story of one such "retired" Maryland physician, Eugene H. Guthrie, M.D., whose career in the U.S. Public Health Service (PHS) included an important role in the 1964 surgeon general's report on the adverse health effects of tobacco use.

In 1963, President John F. Kennedy received a letter jointly signed by officials of the American Cancer Society, American Heart Association, and American Tuberculosis Association (later known as the American Lung Association) stating that smoking was a national problem. The letter asked the President to have the surgeon general empanel a blue ribbon committee to study the issue. Dr. Luther Terry, then-surgeon general, appointed one of his force as staff director and they developed a list of 150 prominent physicians and scientists whose names were circulated among all the tobacco companies, other major industries, physicians, and scientists. From that list and other recommendations, ten committee members were selected. Before the committee had progressed very far with its work, however, the staff director became seriously ill and had to be replaced. Dr. Guthrie, considered by Dr. Terry to be the most competent member of his large department, was chosen to fill the void.



Dr. Guthrie in his St. Michaels study.

While the committee worked, the press and various stock market manipulators were anxious to obtain information about its recommendations. Dr. Guthrie received a telephone call from the Securities and Exchange Commission advising him that, although the SEC had no specific information, it was rumored that leaks were coming from his staff. As a result, the committee's offices were moved from the second floor of the National Library of Medicine to an unoccupied sub-basement, originally built as a bomb shelter, in the same building. Dr. Guthrie stationed round-the-clock guards at the entrance and ordered that only those with clearance be allowed to enter. Nevertheless, about a week later, he found a *Newsweek* photographer taking pictures of the interior. The photographer had been allowed in by a lay staff member who "thought" it was harmless. (The film was retrieved undeveloped, the photographer ejected, and the staff member chastised.) According to rumor, a journal had offered a five-figure reward for advance information about the committee's conclusions.

When the committee's work was almost complete, several proof copies had to be printed for comment and correction. To maintain secrecy, the committee arranged to have its own personnel use the printing presses of other government agencies in the evenings and on weekends, without the other agencies knowing the nature of the material being printed. A different agency was used each time and even the waste from the operation was carefully collected and destroyed.

The final document was printed by that section of the Government Printing Office that regularly handled all secret and restricted documents for the State and Defense departments.

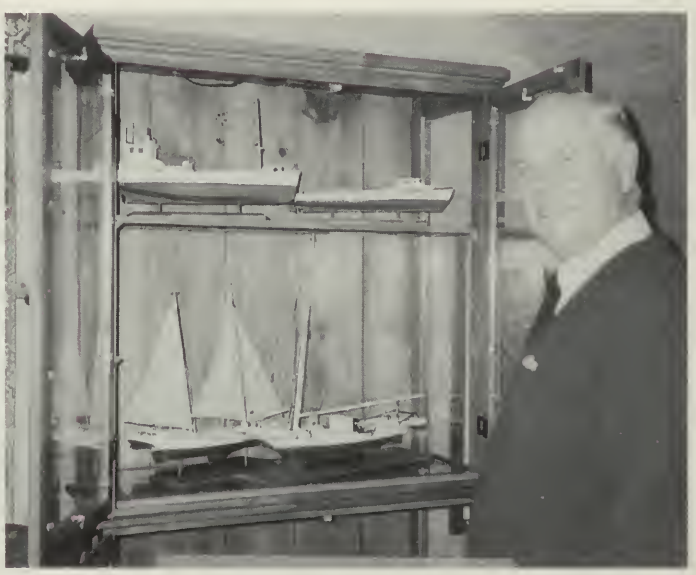
In January 1964, when the official *Surgeon General's Advisory Committee's Report on Smoking and Health"* was to be made available to the public, it was decided to use the State Department auditorium because it was the only area at the time large enough to handle the number of reporters expected. (President Kennedy had used the auditorium for his press conferences, for the same reason.) The room was opened at 9 A.M. on Saturday morning, all accredited persons were admitted, and the doors were locked. A copy of the 387-page report, which had been delivered to the auditorium via armored car, was given to each person in attendance. They were given three hours to review the document and no one was allowed to leave. At noon the surgeon general announced the salient findings of the committee and opened the floor for questions. Committee members were present to provide the answers.

Conservative in its findings, the committee had struggled with the connotations of every word. For example, instead of using the word *addicting,* the report stated that tobacco use was "habit forming." It did announce a definite relationship between tobacco use and the occurrence of lung and lip cancer, but reported only the possibility of a relationship between tobacco use and coronary heart disease, esophageal and bladder cancer, bronchitis, and emphysema.

That Monday, the value of tobacco stock plummeted. There was no evidence of any premature leaks of the committee's findings. For his outstanding achievement in guiding the study, Dr. Guthrie was given the PHS Meritorious Service Award and was recognized by the Associated Press annual poll as the 1964 "Newsmaker of the Year in Science."

Following the publication of the surgeon general's report, Dr. Guthrie returned to his previous activities as chief of the division of chronic diseases. Among the many PHS programs initiated during his four years in this capacity were

- expansion of the cervical cancer program, which reduced the number of deaths from this form of cancer in women;
- advancement of x-ray mammography from experimental to diagnostic use;
- the first chronic kidney disease program in the PHS to support renal dialysis and kidney transplantation;
- demonstration and expansion of the first coronary care units in hospitals and mobile units;
- development of automated telemetry of electrocardiograms and other vital biological information (including a cooperative effort with the U.S. space program);
- development and support of local-community, comprehensive services for the mentally retarded;
- a new program for the early detection of strokes and improved stroke rehabilitation;
- a new program to prevent neurological diseases and blindness, including the encouragement of the routine use of tonometry in medical offices to detect unsuspected cases of glaucoma; and
- a full-time PHS program devoted to the health of the aging.



Dr. Guthrie proudly displays some of the miniature boats he has built.

Born in Washington, DC, in 1924, Eugene H. Guthrie was the second son of Harriet Ellen Harding Guthrie and Dr. Marshal C. Guthrie, a career physician who attained the position of assistant surgeon general in the U.S. Public Health Service (PHS). Throughout his early years, Gene Guthrie pictured himself as a family physician and with this in mind, he enrolled as a premedical student at Haverford College in Pennsylvania. When the United States became involved in World War II, he left college to join the U.S. Coast Guard as a pharmacist's mate, serving in that capacity from 1942 until 1945. After the war, he completed his premedical training at the University of North Carolina and earned his medical degree at George Washington University in 1951.

Dr. Guthrie then sought a reserve commission in the PHS and interned at its Baltimore hospital, where he remained an additional year as the admitting officer. Learning from his commanding officer that training in preventive medicine was available, Dr. Guthrie became a member of the regular corps of the service. He spent a year as a public health resident in the Montgomery County (Maryland) Health Department, a year at the School of Public Health at the University of Michigan in Ann Arbor where he received his master's degree in public health, and a year as a public health resident with the California State Department of Public Health in Berkeley.

By this time, Dr. Guthrie realized that his future was in preventive medicine and that his efforts in that direction could result in greater benefit to more people than if he returned to his original goal of pursuing family medicine. During his PHS career, he served as chief of school health and rural health activities, chief program officer in the bureau of state services, chief of the neurological and sensory disease branch of the division of chronic diseases, chief of the division of chronic diseases, assistant surgeon genteral, and associate surgeon general.

Dr. Guthrie and his wife, Elizabeth (nee Schultz), have six grown children. They live in St. Michaels on Maryland's Eastern Shore, where Dr. Guthrie pursues his hobby of building miniature boats.

In 1966, the succeeding surgeon general appointed Dr. Guthrie assistant surgeon general for operations, giving him responsibility for day-to-day problem solving, interpretation of policy, communications, reporting, and expediting of actions and related activities. Promoted in 1967 to the newly created position of associate surgeon general, Dr. Guthrie became the third ranking member of the PHS after the surgeon general and deputy surgeon general. At that time, the PHS had more than 36,000 employees, of whom 5000 were commissioned officers in more than 500 field locations worldwide.

Although Dr. Guthrie retired from the PHS in 1968, his talents were not to remain unused. Then-Governor Spiro T. Agnew appointed him immediately as the first executive director of the Comprehensive Health Planning Agency for the State of Maryland. Remaining in that position for six years, Dr. Guthrie then became a health systems planning consultant. From 1978 to 1986, he was the deputy state and county health officer for Dorchester and Talbot counties.

Although he has held no official position since 1986, Dr. Guthrie is called upon frequently for advice and guidance. He has received innumerable awards and honors and served on many committees whose activities have focused on the health of school children, migrant workers, and the handicapped.

Regarding the changes that have occurred since the surgeon general's 1964 report, Dr. Guthrie believes progress toward a smoke-free society may have been slowed by the elections last November. Dr. Guthrie has no doubt, however, that the trend is unstoppable and eventually will sweep over not only the United States, but the world.

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The Baltimore General Dispensary: withhold not thine hand

In 1798, three small settlements—Jones' Town, Fell's Point, and Baltimore Town—situated at the upper end of the Chesapeake Bay and with an aggregate population of approximately 26,000, were incorporated as the City of Baltimore. Three years later, the task of supplying the health care needs of its indigent was undertaken by a group of dedicated lay and professional individuals.[1,2]

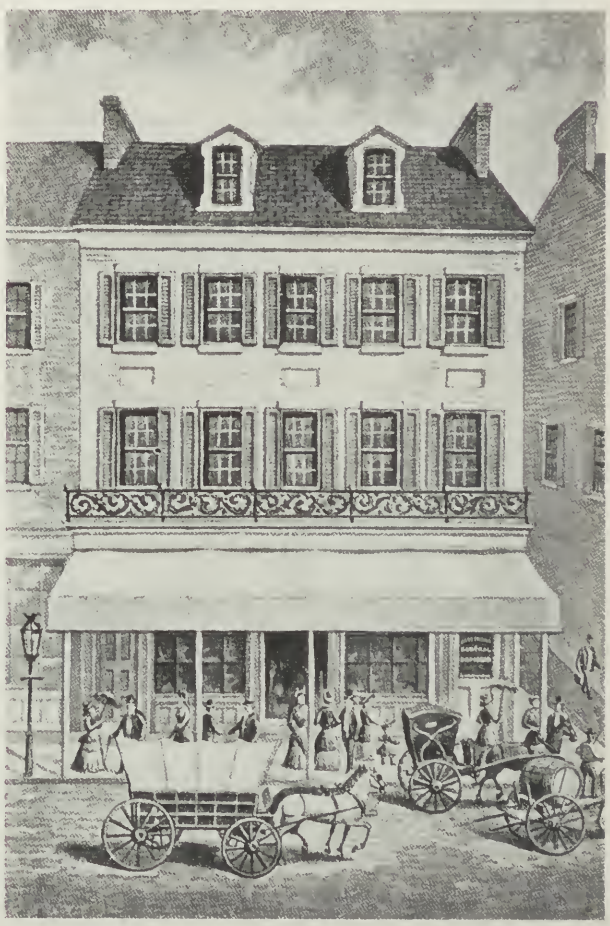
Foundations

Twelve men, including one physician, met at the Indian Queen Tavern on the southeast corner of Hanover and Baltimore streets in February 1801 to form an initially modest but eventually great institution. Thus was fabricated the oldest charity of its type in Baltimore and, perhaps, in the United States: the Baltimore General Dispensary. The clergy of various denominations were well represented on the Board of Managers. Among them were Reverend Joseph G.J. Bend, Bishop John Carroll (the first Catholic bishop in the United States and later archbishop),[3,4] Bishop James Kemp, and Reverend Daniel J. Kurtz. At a later date, Enoch Pratt was vice-president and a member of the Board of Managers.

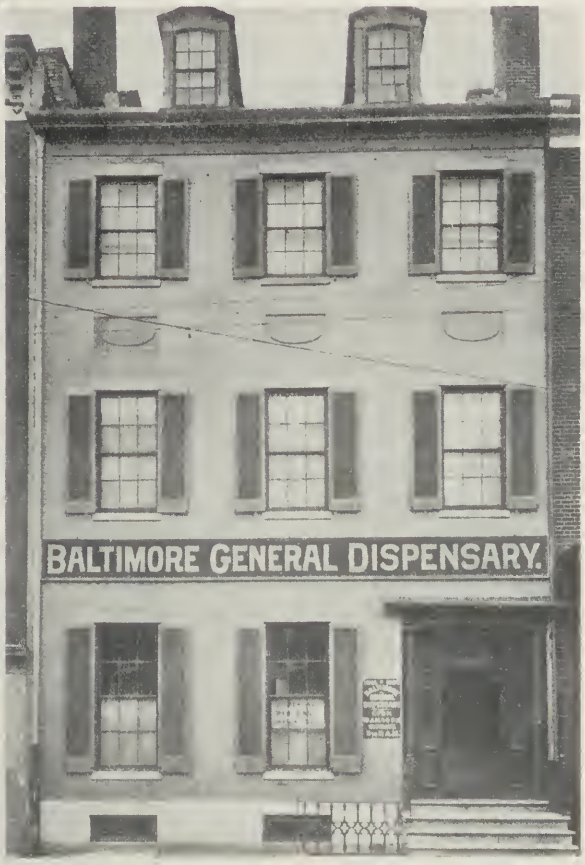
Financial contributors had the privilege of referring patients to the Dispensary, a dispensation that was further delineated in February 1803: "Every person, who shall pay annually the sum of five dollars into the hands of the treasurer shall be entitled to the privilege of having patients under the care of the Dispensary, while such person shall continue to be a contributor. And the payment of fifty dollars at once, shall entitle the contributor and his or her lawful representatives to the privilege of always having patients upon the Dispensary." Rules for providing care were clarified in 1805: "Resolved, that the benefits of this institution are not to be extended to any bond servant or slave, or to any other person who may be considered competent to the payment of a physician."

In February 1801, Dr. John Worthington Dorsey was chosen apothecary for the institution at $400 per annum. In addition, Dr. John D. Smith was elected to furnish medicine in the Eighth Ward, for which he was to receive $200 a year. The other attending physicians served without pay.

Ten attending physicians elected for 1802 were each assigned a district in which to provide care. In 1803, their salary was established at $300 for the year. Although the remuneration was small, not a few of the young physicians who served faithfully in the Dispensary derived almost their entire income from this salary. In 1814, the funds of the institution were seriously depleted and the attending physicians were informed that their services could not be compensated. In all, about 170 doctors served at the Dispensary at its termination; perhaps there are more whose names are unknown. The work these



The first home of the Baltimore General Dispensary (1801-1803), at 127 Baltimore Street (courtesy of the Baltimore General Dispensary Foundation).



From 1893 to 1912, the Dispensary was located at 651 West Lexington Street (courtesy of the Baltimore General Dispensary Foundation).

men accomplished is truly amazing because they always tried to better the service or help the helpless.

The work of the Dispensary having been firmly established by 1807, the managers applied for and received a charter from the General Assembly of Maryland. The institution was the third so commissioned in Maryland, preceded only by the Equitable Fire Company and the Bank of Baltimore.

The first home of the Dispensary was at 127 Baltimore Street, at the southeast corner of Public Alley (now Grant Street). In 1803, the Dispensary moved to Light Street, where the rent was $10 a month. Within a short period, however, another move was made to Chatham (now Fayette) Street. In all, the Dispensary had ten locations in downtown Baltimore. Two buildings were especially constructed for the group: one at Liberty and Fayette streets and the other at Paca and Fayette streets.

Services and devices

Vaccination against smallpox with virus obtained from London had been introduced in Baltimore by Drs. John Crawford and Miles Littlejohn (consulting physicians) and James Smith (attending physician). As early as 1803, the rules of the Dispensary stated, "the mitigation and danger and evils of the smallpox, or prevention of it by the kinepox, shall be likewise an object of the Institution." Indeed, Dr. Smith may be appropriately called "the father of vaccination" in Maryland. The Medical and Chirurgical Faculty endorsed and aided his efforts to form a Vaccine Society. Here, again, men prominent in the affairs of the Dispensary gave aid. In 1822, the group resolved "that in order to facilitate the practice of vaccination, the management of the Baltimore General Dispensary shall take such measures deemed necessary to preserve a constant supply of genuine vaccine matter with a view toward extending the benefits of its use." In that year, 1,437 vaccinations were performed at the Dispensary.

In 1804, a Humane Society was added to the medical structure. One of the tasks of the new branch was the recovery of drowned individuals from the harbor. For this purpose, a drag was necessary and $35 was appropriated for its construction.

One other device created was a small bellows with a curved nozzle and a flexible tube with a sliding valve on the outside of the hose, so placed as to make the bellows fit for the purpose of exhausting impure air from the lungs and filling them with pure air. In some way, the early Dispensary physicians had grasped one of the fundamental ideas now being used in cardiopulmonary resuscitation.

Funding

Provision of financial support to keep the institution viable was a constant task for the managers. Some fees were generated by individual contributors, but the sums could hardly care for the needs of the institution. A public appeal was made in 1805 and the managers expressed their confidence in obtaining the required help when they stated, "Those of Baltimore yield the palm of benevolence to none upon the continent and they anticipated a successful result of the their appeal." Donations of larger sums also were made by a small group

of individuals, but this money, too, did not completely pay the bills. A law was enacted by the legislature at that time authorizing the Dispensary to run a lottery, but no record exists to indicate the method was used.

A most unusual source of funds was provided in the original charter: "That all fines imposed in Baltimore County on persons convicted of keeping houses of ill-fame shall be and are hereby appropriated to the use of the said General Dispensary and when collected shall be paid to such person as the President and the Managers shall appoint as their Treasurer." In 1809, the treasurer reported that he had received $85 from the sheriff of Baltimore County for this infraction of the law the previous year. In addition, funds were derived from a concert of the Handelian Society of Christ Church.

A number of bequests were made through wills, and one of the best known is the Wilson Fund, established in 1852. Dr. William T. Wilson left $5,000 to the Dispensary for a very specific purpose. Because of their intimate relations with the patients, Dispensary physicians rapidly became aware that treatment of the indigent often required more than medicine. The necessities of food and fuel were frequently lacking and Dr. Wilson was firm in his belief that many who came to the Dispensary required these needs. He stipulated that the income from the fund be expended solely for "the purchase of clothing, bedding, fuel, and dietary foods for the poor sick persons within the City of Baltimore."

Until 1894, the Dispensary existed in a precarious way on donations of various types, but then the managers applied to the City Council for aid. In 1900, the Supervisors of City Charities set forth the conditions upon which the Dispensary would be paid for treating city patients. They could charge ten cents for giving medical advice and drugs or for filling a prescription written by an outside physician. Payment would not be made until forms provided by the city were completed and returned. Although the fee was small and the task of completing the forms was onerous, the managers were grateful for the regular assistance.

A helping hand

Although their funds were short, the managers were ever ready to help others. When the Orphaline Charity School requested that the doctors of the institution see sick children, the trustees of the school were informed that such children were eligible for care if they were recommended by a contributor. The managers also provided care for lost children. The apothecary was directed to obtain a receipt for them when "he delivered them up."

The welfare of the entire community was genuinely held in heart by the managers. During the winter of 1902–1903, considerable illness due to damp and cold weather existed and coal for heating was in scarce supply. At his own expense, one of the managers purchased a carload of nut coal—30 tons—and had it delivered to the Dispensary, where the poor could receive one peck at a time. Distribution of fuel was so satisfactory that further contributions enabled the pur-



Baltimore General Dispensary Staff (1907-1914). From left. Dr. Henry M. Baxley, physician in charge; Dr. Edward E. Mackenzie and Dr. Edward A. Munoz, attending physicians; Miss Alice G. Harman, nurse; and Mr. George P. Costello, apothecary (courtesy of the Baltimore General Dispensary Foundation).

chase of another carload, which was distributed in a similar manner.

Statistics

Eight nurses were associated with the Dispensary during the period of 1901–1941. Alice G. Harmon, the second in this series, served from 1907 to 1916. Women physicians, however, were never members of the attending staff, a fact consistent with the paucity of female doctors during the period.

Any review of the work of the Dispensary would be lacking without a note of its statistical accomplishments. During the 158 years the organization tended to the poor of Baltimore, 950,310 patients were seen and 1,569,311 prescriptions were filled. As the city grew, so did the number of people asking for care. The period of 1901–1910 was one of particular stress: more than 128,000 patients were seen and were given more than 197,000 prescriptions.

An obligation to care

The adjective that best describes the characteristics of the Board of Managers and physicians is *hospitable*. This feature of the semi-nomadic life of the patriarchal era was depicted in Genesis when the care of the stranger was considered an obligation. These men, who exhibited a greater share of kindness and hospitality than is generally appreciated, seemed bathed with an element of love for mankind. Their reward for the indulgence of their emotions must have been an unusual state of exhilaration and the feeling of a job well done.[5-7]

One of the more noticeable things about the management and medical conduct of the organization during its long history was the presence of families. A number of them, the most numerous being the Baxleys, may be found in the group.

In 1959, the Board of Managers realized that the usefulness of the Dispensary for providing for the indigent sick had been declining for a period of years. The medical functions of the Dispensary had been duplicated and overlapped by other facilities in Baltimore. It was apparent that its assets could be used to better advantage by closing the institution and diverting its funds elsewhere. Like the mythical Arabian phoenix, the Dispensary self-destructed to rise again with a restatement of its charges and the formation of a foundation which is still active. A number of charities are being supported by interest from the investments of the organization.

In 1872, the president was authorized to procure a suitable seal for the Dispensary. The inscription epitomizes the entire work of the institution. Taken from Ecclesiastes 11:6, it reads "Withhold not thine hand." This portion of Ecclesiastes is not easy to interpret, but the thought presented is the principle of the Golden Rule: "Do unto others as you would they would do unto you."

Casting bread upon the waters is not charity given for selfish ends, but charity given in confidence that a sure order exists in the world under the deft control of God.

JOSEPH M. MILLER, M.D.
Dr. Miller is a retired surgeon in Timonium, Maryland.

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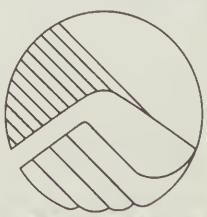
COMING OUT OF THE DARK

Med Chi's Physician Rehabilitation Committee deals with the substance abuse and mental health problems of Maryland physicians, with a confidential and nondisciplinary focus...Addiction, Marital/Family Conflicts, Psychiatric Illness, Organic Impairment, Physical Handicap...If these problems exist, we can help find the solution. Call us.

The Physician Rehabilitation Committee of Med Chi is available to all Maryland physicians, and their families. The Committee is NONDISCIPLINARY and information is kept CONFIDENTIAL. If you, a colleague, or family member is in need of our services call (410)962-5580 or call toll free (800)992-7010, or leave a message 24 hours a day, 7 days a week at (410)727-1020.

HELPING IS OUR BUSINESS...All donations to the Physician Rehabilitation Committee are used for the delivery of services to Maryland physicians in need of help. If you wish to help further the work of the Committee through a tax deductible donation send your check to: The Medical and Chirurgical Faculty Charitable/Educational Foundation, 1204 Maryland Avenue, Baltimore, Maryland 21201 Please note on your donation: "Physician Rehab"

Medical and Chirurgical Faculty of Maryland



Physician Rehabilitation Committee

Books, Etc.

The Quest for Cost-Effectiveness in Health Care. Achieving Clinical Excellence While Controlling Costs. Jeffrey P. Trotter. Chicago, IL: American Hospital Publishing; 1995. 116 pages. $28 (AHA members), $35 (nonmembers).

Quality assurance, health care costs, and cost-effectiveness are terms too frequently used in the daily conversations of physicians, hospital managers, and most other health care providers. Hospitals today scarcely resemble those of a few years ago as the health care environment changes rapidly. Hospital managers understand that to survive hospitals must strike a clinical and economic balance and provide better care at better cost. They are in the business of improving the health status of the people by providing high quality care while under fixed reimbursement and efficient management of resources.

Now a recent, interesting book addresses the issue of "the quest for cost-effectiveness in health care" and how to achieve clinical excellence while controlling costs. The author, who holds a master of management degree, is president of a health economics and outcomes research and consulting firm.

It is a well-written book divided into six chapters. It aims to help readers understand the concept of cost effectiveness, its application, and its embracement by decision makers in a variety of settings. It provides the health care community with the tools and perspectives for achieving better clinical outcomes while managing costs. Some health care providers who strive to provide high quality care may realize that with careful and diligent evaluations, low overall costs and excellent clinical outcomes are not mutually exclusive. As the author emphasizes, "the more appropriate goal may be to select the product that works the best while maximizing patient satisfaction, enhancing the patient's quality of life, requiring the least consumption of resources, and incurring the least cost." The book shows how to lower overall treatment costs through cost effectiveness analysis and how to develop an effective cost management action plan.

The book provides several figures and tables that further clarify the points of overcoming obstacles and implementing successfully a cost-effectiveness program. There is, however, a paucity of references and lack of an index. Still, this publication is stimulating and may prove to be a welcome guidebook for hospital medical staffs, administrators, managers, and directors of ancillary services.

CHRIS PAPADOPOULOS, M.D.
Book review editor, Maryland Medical Journal

■ ■ ■

Managing Your Child's Diabetes. Robert Wood Johnson, IV, Sale Johnson, Casey Johnson, and Susan Kleinman. New York: MasterMedia Limited; 1992. 199 pages. $12.95 (softcover).

This book describes firsthand how one family has learned to cope with a child's diabetes. The authors offer a very limited, but useful perspective on how to deal with diabetes in a child.

The book takes readers through many of the day-to-day management issues of type I diabetes, primarily from the parents' perspective. The first chapter includes the feelings of the child herself. Subsequent chapters describe dealing with diagnosis, hospitalization, choosing a doctor, dealing with blood sugar testing and giving insulin, practical aspects of how to live with diabetes at school and on vacation, and the effect on the rest of the family. The authors also

include comments from other parents and experts on these problems. The last chapter describes research in progress for the future of diabetes and the appendixes list many resource sites for patients to contact.

The authors have done their research well, and their comments and feelings will strike true to many parents of diabetic children. The parents and the child, however, are unique in that there is a great deal of discussion about mood swings and sugar levels that may not be typical of the majority of childhood diabetics. The parents are far more sophisticated, with substantially more resources, than the average family.

Still, the book will be useful for parents of children with diabetes.

JAMES M. MERSEY, M.D.
Editor, A Clinical Moment with Endocrinology and Metabolism, Maryland Medical Journal

■ ■ ■

Medicine and the Media: A Changing Relationship. The Cantigny Conference Series. Chicago, IL: Robert R. McCormick Tribune Foundation; 1995. 106 pages (paper).*

This book is a compilation of a conference held in October 1994, to explore the relationship between medicine and the media, how it evolved, and where it stands today. The meeting reported is one of the "Cantigny Conference Series," which "offers the opportunity for collaboration between the foundation and other institutions or associations that are addressing issues consonant with the foundation's mission." Cantigny is the McCormick Estate located in Wheaton, Illinois, about 30 miles from Chicago.

The book is a 106-page highlight of the opinions rendered at the conference. It focuses on "how the medical community and the news media go about supplying the public with objective, understandable, and complete information about medical and scientific research." Specific topics addressed include: Are Medicine and the Media Partners or Antagonists?, Who's Responsible to Whom—And For What?, and Conflicts of Interest.

The conference was attended by 41 leaders in the fields, including editors and others from the leading medical journals and prominent science writers from the major news media. They questioned the credibility of some articles, noting that there is a tendency for reporters to accept what they have been told by physicians or other researchers or from their published articles, without any investigative reporting, which might suggest bias, conflict of interest, fraud, or sloppy or otherwise incompetent work. One participant stated, "Reporters are supposed to check things out. They should know enough about the field they cover to smell a rat when there is one—and also to recognize true genius." He stressed that reporter should not act only as stenographers.

An example noted was the publication of a study by a neuroanatomist who studied the brain structure of homosexuals and heterosexuals and found a difference. The panel member believed that because the researcher was a homosexual, he might have a conflict of interest. The manner in which drug companies manipulate the dissemination of articles favorable to their products also came in for much criticism.

The volume should make interesting reading for both physicians and the laity. It should also make the reader more alert and discerning of what he or she finds reported in the press and magazines and on television.

MARION FRIEDMAN, M.D.
Dr. Friedman, a retired Baltimore family physician and internist, is a member of the Maryland Medical Journal *editorial board.*

*For cost and availability, contact The Robert R. McCormick Tribune Foundation (312-222-3512).

To Our Readers

The Editorial Board of the *Maryland Medical Journal* invites you to submit reviews of books, videos, and films of interest to the medical profession. Bringing your evaluation and analysis to the attention of your colleagues will be informative and stimulating. Send your report to: Chris Papadopoulos, M.D., Book Review Editor, *Maryland Medical Journal*, 1211 Cathedral Street, Baltimore, Maryland 21201.

What Your Patients
MAY BE READING

- "Top Docs"
  Baltimore, June 1995
- "Vaccine Troubles"
  Out, June 1995
- "Could You Have Candida? How To Recognize and Beat It"
  She, June 1995
- "The Post Investigates Folic Acid's New Role in Heart Disease Prevention"
  Saturday Evening Post, June 1995
- "Stop Worrying About Your Heart"
  Men's Health, June 1995
- "The Surgery Every Woman Should Question"
  McCall's, June 1995
- "The Last Word. How Did DSM Become Psychotherapy's Highest Authority?"
  The Family Therapy Networker, May-June 1995
- "Could Migraines Increase Your Risk of Stroke?"
  Vogue, June 1995
- "Exercise and HIV Infection"
  The Advocate, May 30, 1995
- "Dangerous Medicine! What Pediatricians Wish You Knew"
  Child, June/July 1995
- "Take Charge of Your Health. America's Top Woman Doctor Tells How"
  Ladies' Home Journal, June 1995
- "The Herbal Medicine Chest"
  Men's Fitness, June 1995
- "Closing In on a Cancer Cure"
  21st Century Science & Technology, Spring 1995
- "Nature's Prozac"
  Natural Health, May/June 1995
- "A Place in the Sun"
  Genre, May 1995
- "Back in the Stirrups Again? Here's How to Make the Most of Your Visit"
  Mademoiselle, June 1995
- "Germ Invasion. Scary New Diseases"
  Shape, June 1995
- "The Mood-Swing Virus"
  Longevity, June 1995
- "When Bad Genes Happen to Good People"
  Technology Review, May/June 1995
- "Pregnancy and STDs"
  New Woman, June 1995
- "Cure Your Own Back Pain"
  "Herbal Remedies. A Guide You Can Trust"
  Health, May/June 1995
- "Are Natural Cures a Prescription for Danger?"
  Redbook, June 1995
- "Anti-Aging Alert. 4 Treatments That Let You Live Longer"
  Self, June 1995
- "PMS: Relief at Last"
  Reader's Digest, June 1995
- "Sun's Up! Save Your Skin"
  Glamour, June 1995
- "Faster Chest-Pain Tests"
  Muscle & Fitness, July 1995

Health care fraud and government investigators

The assignment of a substantial number of FBI agents to health care fraud investigations has resulted in a flurry of investigative activity far beyond that experienced in any prior years. Indeed, a press release issued March 2 by the U.S. Department of Justice states that federal investigations have quadrupled during the past four years. An increasing number of investigations are the result of *qui tam* suits filed by private relators (usually employees of the target organization) acting as private attorneys general prosecuting false claims filed with the government. *Qui tam* suits (*who as well*; i.e., the plaintiff states that he sues as well for the state as for himself) are authorized by the Federal False Claims Act and may be brought by any citizen with respect to false claims that have been filed with the federal govenment. Once a *qui tam* suit has been filed, the government has the option of pursuing the prosecution itself. Such cases are filed under seal (i.e., you do not know you have been sued) while the government investigates the allegations to determine if it wants to take over the case. Private relators are entitled to a significant percentage (up to 30%) of any penalties and recovery if they or the government pursues the matter to recovery. *Qui tam* suits already have been filed asserting prohibited referrals under Stark II.

In addition to more investigative activity, there has been an increase in the use of search warrants and "forthwith" subpoenas—as opposed to the more common production of documents—in response to an administrative subpoena issued by the Office of the Inspector General. In one recent instance, FBI agents, postal inspectors, and Medicaid fraud strike force team members carrying a search warrant converged on the main office and all branches of a provider and demanded immediate production of all documents covered by the search warrant. All of the officers and employees were herded into the reception room and told to wait there while offices were searched and records, including patient records, were removed. In another case, investigators appeared at the premises with a subpoena that required the production of voluminous records before the grand jury "forthwith." Investigators demanded that all of the desired records be boxed up and taken immediately to the state attorney general's office, where copies would be made and sent back to the provider.

These actions deserve some comment. Any advice regarding such a situation obviously starts with the words, *Call your attorney immediately*. In the meantime, however, be aware that investigators have no authority whatsoever to exclude you from your own premises when they are being searched. It is not an obstruction of an investigation for you to observe the search and what is being taken. You have a right to an inventory of what is taken, and the inventory must be more specific than "28 boxes of written documents."

In the case of a "forthwith" subpoena, you have a right to make copies of the documents that are being taken. It is crucial to know what documents are taken in order to evaluate any charges subsequently asserted against you. A forthwith subpoena does *not* require that documents be surrendered to the agent; the subpoenaed party has an absolute right to refuse immediate surrender in favor of personal production of the documents to the grand jury. That delay allows time for consultation with counsel and document copying.

If an investigator appears at your premises, insist on identifying each individual involved: obtain cards or copy down names, agency, address, and position with the agency. Although you cannot delay a search until your attorney appears, you do not have to submit to any interviews or answer any questions posed by investigators. If you are willing to talk to investigators, it is preferable to do so after consulting or in the presence of your attorney. Although you may not think you have violated any laws, in most cases you really do not know. Arrangements that are perfectly acceptable in any other industry may, in the health care industry, be subject to heavy civil penalties, exclusion from the Medicare/Medicaid programs, and criminal sanctions.

LEONARD C. HOMER
Mr. Homer, a Baltimore attorney specializing in health law, is chairman of the health law department of the law firm *Ober, Kaler, Grimes & Shriver.* ■

A massive federal probe was launched last year after an anonymous whistle-blower filed a private lawsuit under the False Claims Act alleging 130 hospitals had improperly billed the government for medical care involving non-FDA-approved experimental devices. In response, several hospitals nationwide, including Hopkins, have sued the Department of Health and Human Services seeking to overturn the government's decision to deny payment for that care.

1995 Presidential Banquet

On the evening of Saturday, May 6, 1995, nearly 400 people gathered to celebrate the beginning of Dr. J. Richard Lilly's term as president of Med Chi. This elegant event, held in the ballroom of the Inn and Conference Center, University of Maryland, College Park, featured a lovely dinner followed by presentations including the Past President's Plaque, a Governor's Citation, and the Henry and Page Laughlin Award. Zim Zemeral Orchestra provided a variety of background and dance music for the evening. The members and guests had the privilege of meeting and welcoming the Governor and First Lady of Maryland, the Honorable and Mrs. Parris N. Glendening.



Drs. J. Richard and Elizabeth Lilly enjoy the company of their family, friends, and colleagues.

Many different organizations showed support and attended the celebration: BlueCross BlueShield of Maryland; Calvert Memorial Hospital; Dimensions Health Corporation; Doctors Community Hospital; Greater Laurel Beltsville Hospital; HealthPlus; Maryland Medical Political Action Committee; Mason, Ketterman, and Morgan; The Med Chi Insurance Agency, Inc.; Medical Mutual Liability Insurance Society of Maryland; Naden Lean CPAs; O'Malley and Miles; Prince George's County Hospital; Suburban Bank; and Washington Adventist Hospital. In addition there was a large attendance of Med Chi physicians, especially from the Prince George's County Medical Society.



For his leadership role in the Maryland Family Physicians' Campaign Against Family Violence, and for his public health initiatives with tobacco control and perinatal care, Dr. Martin P. Wasserman, Secretary of the Department of Health and Mental Hygiene, was awarded the Henry and Paige Laughlin Award, created to award individuals who display outstanding leadership and citizenship in Maryland.

George S. Malouf, Sr., M.D., Med Chi AMA Delegation Chairperson and a close friend of Dr. Lilly, served as master of ceremonies for the event. The invocation was given by Reverend Norris Syndor, pastor of Riverside Baptist Church in Ft. Washington and member of the Board of Trustees, Doctor's Community Hospital. Befitting the inauguaration of a family practice physician as president, the evening's speeches developed a theme of family—the traditional family, the family of medicine, and the extended family.



Dr. Donald H. Dembo is presented with his Past President's Plaque as well as his Past President's Pin and Med Chi Watch.

1995 Presidential Banquet

George Malouf, Sr., M.D., Master of Ceremonies
BANQUET SPEECH



Maryland Senator Arthur Doorman presents Dr. Lilly with a certificate from the Senate of Maryland.

As the first order of business, I would like to welcome you to the Med Chi Presidential Banquet and thank you for sharing this very special evening with us.

We are honoring tonight our President, J. Richard Lilly, M.D. For this, I am delighted. The honoree is an accomplished physician, favored by his patients and respected by his peers. He is one of the architects that established the Department of Family Practice at the University of Maryland and the first chairman of the Family Practice Department at the Prince George's Hospital Center. I am also proud to say Dr. Lilly is my doctor. His leadership at the county and state level is a matter of record and serves as a role model. I know, on his watch, medicine is in good hands.

As we pass the torch from one president to the next, we also pass a legacy of our commitment to maintain and elevate the standards of medical education, medical care, and medical ethics in Maryland. We recognize that the health care system, *not health care*, needs improvement. But we must never forget that the physician is the custodian of health and, as its custodian, we must be ever attentive and mindful of our responsibility to maintain quality care, prevent and treat disease, alleviate suffering, and promote healthy living. My friends, your medical society and its member physicians restate its pledge to you to be ever vigilant as the advocates for our patients. Let me remind you that we were mandated by an Act of the General Assembly of Maryland to oversee the quality of health care. On January 20, 1799, we were directed as outlined in the Preamble of the Act, and I quote, "to promote and disseminate the Medical and Chirurgical knowledge throughout the state and to prevent the citizens of Maryland from risking their lives in the hands of ignorant practitioners or pretenders to the healing art." The Act was signed by Benjamin Ogle, the tenth Governor of the State of Maryland. Governor Ogle was a man of great qualities, sound sense, and good judgment as described by his good friend, George Washington. History tells us that the Governor lived, until the end of his days in 1808, on his estate near Bowie in Prince George's County.



Dr. Donald "Ted" Lewers, AMA Trustee and Med Chi Past President, and his wife, Pat.

As we look forward with a sense of pride and great anticipation to our bicentennial, in less than four years, we feel that we have a date with history. History is about to repeat itself. Governor Glendening is from Prince George's County like Governor Ogle, and he, too, like Governor Ogle is a man of great qualities, of sound sense and good judgment. The celebration will occur on his watch.

Ladies and Gentlemen, our Society lived up to the trust of the General Assembly and the confidence of Governor Ogle. It will be fitting on the occasion of Med Chi's bicentennial that the Act of 1799 be reaffirmed by the General Assembly and signed by Governor Glendening.

1995 Presidential Banquet

J. Richard Lilly, M.D.
BANQUET SPEECH

Ladies and Gentlemen, I have good news and I have bad news. The good news is that my predecessors have mandated to me that my introductory remarks be brief, to the point, and light. The bad news is that very few things that I do say are brief, so please bear with me.

I would like to begin with a story that I believe all in this room can relate to. About one month ago I made a quick visit to my oldest son John's home on the way to a hardware store, and while talking to John, my grandson, Johann, who was at the time 3 and 3/4 years of age, insisted that I see his merry-go-round in the back yard. As hastily as I could, I watched Johann spin a few times and then made my way back to the car in an effort to continue my chores. It was obvious that Johann wanted more of my time and was upset when I left him swinging on the merry-go-round. I walked to my car to get in when Johann, in the presence of his father, picked up a claw hammer and began to beat the hammer on the concrete and inflicted a few chips here and there. His father immediately told him that this was not acceptable and that he had to stop. He put the hammer down and when his father turned away for a second, Johann went into the garage and picked up an axe and began to hit the concrete on the garage floor. His dad then became a little bit angry and had to demonstrate further control. As I drove away from the episode, with Johann sitting for a time out,



The Honorable Wayne Curry, Prince George's County Executive, and his wife, Sheila.

Be it known, that on behalf of the citizens of this state, in recognition of one of Maryland's most respected and admired members of the medical profession...a man whose dedicated efforts to raise the status of primary care physicians has made a lasting impact on family practice and family residency programs throughout our state – and as an expression of our admiration and gratitude for someone whose continuing contribution to quality health care for the people of Maryland serves as an inspiration to all, we are pleased to confer upon you this Governor's Citation.



Governor Glendening presents Dr. Lilly with a Governor's Citation. L to R: Governor Glendening, Mrs. Glendening, and Drs. J. Richard and Elizabeth Lilly.



Dr. Joseph Snyder, 1993-1994 Med Chi President, and Dr. Donald H. Dembo, Immediate Past President, enjoy the company of Dr. Louis Keeler, President, Medical Society of New Jersey.



Governor Glendening and Dr. Lilly share a moment with Dr. Lilly's mother.



L to R: Dr. and Mrs. Suresh Gupta, Drs. J. Richard and Elizabeth Lilly, Dr. and Mrs. George Bone.

it occurred to me what had happened. Obviously, my grandson needed more of my time and acted out in frustration because of the lack of my time. That evening, my youngest son, Donald, called me from Florida, and as we talked I explained the story to him. I said, "How many times when you were growing up was I not there for you and your brother, or did I leave too early?" I recalled the Boy Scout race of the model cars when I had to go to the office one evening and Mom had to be there. Donald said, "Dad, don't worry, because Mom was always there."

Ladies and Gentlemen, this story which I just so recently experienced has been the story of my life and the lives of all the physicians in this room as well as the legislators and all of us who have had to climb that mighty mountain of achievement. This truly means that along the way, there are major sacrifices to our family. None of us could have made the accomplishments without the support of our spouses and wives over those long years of maintaining a balanced household, juggling children's schedules, and attending to the other activities of childhood. Additionally, my wife was able to balance our children's lives and maintain her own practice as a busy psychiatrist. Once again, she is lending her support to me as I embark upon the presidency of Med Chi in a year that will again take away precious family time.

In addition to honoring my wife, Elizabeth, I would also like to honor all of the physician spouses who are here tonight and who have "been there" when their spouses have been on call for those endless evenings of commitment and dedication to patient care— holidays, weekends, Christmas, Thanksgiving, etc. The sacrifices you have made, in the major responsibility of raising the children, have enabled my colleagues to do what they do best—practice medicine. On behalf of my fellow physicians, I salute you and thank you for your generosity of spirit.

As I glance through the room this evening, I acknowledge the fact that the political profession is similar to medicine. Indeed, it requires the same Marine Corps discipline that medicine requires of physicians. Frequently, the political world re-

quires that statesmen be away from their homes to attend hearings, meetings, political functions, and, indeed, their time is eroded much the same as ours. It is this unique similarity that brings us together this evening.

One special family who comes to mind, as we acknowledge the similarity between medicine and politics, is a family that I have come to know personally over the years and respect their commitment to each other. The family is our first family of Maryland, the Glendening family. Through the years, I have watched the care and devotion that one particular member of that family, Frances Ann, has given to her family. Frances has always "been there" for her husband, Parris, and for their son, Raymond. As the nucleus of this family unit, Frances Ann exemplifies those attributes of self-sacrifice and family devotion. She has raised a wonderful young man who has been able to achieve a straight A average at Dematha High School here in Hyattsville. Raymond and I met in the delivery room at Prince George's General Hospital, where I believe Frances Ann was the first or second delivery in the birthing-in suite. Beyond this, Frances Ann has obtained an undergraduate and master's degree from the University of Maryland and a law degree from Catholic University. She has juggled a personal career as the chief legal and policy advisor to the chair of the Federal Elections Commission, with activities of family, and has been a compelling leader with the hospice care program in Prince George's County, as well as being the first lady of Prince George's County for 12 years, and is now the first lady of the State of Maryland.



Dr. Alex Azar, Med Chi President-elect, and his wife, Wilma.



Dr. Lilly presents Mrs. Glendening with a gift symbolizing her role as Maryland's first lady and also her role as a mother, honoring her for always "being there" for her family and setting a stellar example for all the families in Maryland. The gift is an image of family life—a mother's bouquet.

One of the advantages of spending my adult life in family practice is the remarkable and never-ending involvement with the lives of families. Over the years, I have shared in the joy of many births, marvelled at the continuous diversity of the individuals who constitute a family, and have tried to help families deal with the ever-changing world about them. Many of the social changes that have occurred over the past decades—high divorce rates, single parent households, and careers that constantly demand greater amounts of our precious time—appear to threaten our family. Despite forces working against it, the family has not surrendered. Instead, it has evolved by developing new relationships, establishing new ground rules, and adapting its roles and expectations.

As the world has changed for our individual families, so has it changed for the family of medicine. The older members of the family have watched our profession change before their eyes. We've seen advances in technology simultaneously improve patient care and raise patients' expectations beyond the capacity of any technology. And we've seen the nuclear family of doctor and patient become the extended family of



Dr. Lilly's family, L to R: (seated) his youngest son, Donald, Donald's fiancee, Diane, his mother, Dorothy, his brother's fiancee, Pat, and his brother, Robert; (standing) Diane's parents, Dr. and Mrs. Hernandez, Dr. Lilly's daughter-in-law, Victoria, and his oldest son, John.

doctor, patient, insurance company, and government. The members of this extended family, as with most extended families, come from different backgrounds and have varied interests and ideas. Each member views the other warily, constantly assessing the other's motives, plans, and actions. Yet, despite our differences, we have a common link. That link is the care and well-being of our patients and clients achieved through affordable quality care, the availability of technology and services, and the equitable distribution of health care dollars. Many times this extended family is like a family of squabbling siblings, each trying to get the upper hand and each trying to have the last word. Just as our own families have adjusted to social and economic changes, the family of medicine needs to be adaptable and willing to forge new relationships in order to develop a cohesive strategy to deal with the challenging and dynamic environment ahead of us. The care and well-being of our patients and clients should be the motivating force that moves us toward building a medical delivery system that recognizes and serves the needs of Maryland's citizens.

It is with these thoughts that I enter my presidency. Much as the new expectant father anticipates that his unborn child will be healthy and full of accomplishment, I stand before you tonight with anticipation that the family of medicine and its extended family will forge new relationships and work together to make Maryland medicine truly responsive to the people it serves.



The Governor and Mrs. Glendening visit with Dr. Lilly.

To my family, to my fellow physicians, to my friends, to the elected and appointed government officials, and to the first family of Prince George's County, Mr. and Mrs. Wayne Curry, and to the first family of the great state of Maryland, Parris, Frances Ann, and Raymond Glendening, I am most humbled by your presence this evening and must say that this honor is second only to my marriage, the births of my children and grandchildren, and to the receipt of my medical degree. I pledge to all of you to do my very best as President of Med Chi, and hope that I will meet the expectations that my peers have requested of me.

Alliance

President's Inaugural Address

President Tippins, ladies of our Alliance, gentlemen and guests; I am deeply honored to have been chosen to be president of the Alliance to the Medical and Chirurgical Faculty of Maryland for the forthcoming year. I hope with all my heart that I can live up to your expectations and serve you well. I am especially honored that our national president, Barbara Tippins, has taken time from her busy schedule to be with us. Barbara, I deeply admire the wisdom, tact, and knowledge you have brought to the presidency of our Alliance. To head an organization that numbers more than 80,000 members is no easy task.

Since I first became involved with our Alliance a number of years ago, I have been impressed by the loyalty and devotion of its members. You stand side by side with your spouses in a spirit of public service and dedication to the improvement of health services to people of the Free State. The officers of our county chapters and our state Alliance have selflessly given their time and talents to the improvement of our organization, and with your help, I will try my best to carry on their good work. I have been fortunate in that during the past year, I have been able to work with and learn from our immediate past-president, Adriana Zarbin. She has served us well and I ask you to join with me in a standing round of applause for her in appreciation of a job well done.

As most of you know, one of my hobbies is cooking. Today I would like to prepare for you a traditional Persian dish called *khoresht*, the Persian word for stew. First, we must use our utensil. It should be a capacious, sturdy vessel, tried and true, that we know will hold all of our ingredients. Our pot is the Alliance to the Medical and Chirurgical Faculty of Maryland. It has been in our family for generations, and we know that with proper care, it will last for many more generations to come.

Now, what is the first ingredient we need, the basic thing upon which we depend for a successful stew? It is meat, and the meat of our Alliance is its membership. Without this, none of the other ingredients will be able to produce a palatable dish. We must constantly strive to increase our membership by diligent and ongoing recruitment of new members and by keeping our present membership active and interested. To make this work, we must add a little cooking oil in the form of leadership. The county officers who are the backbone of our Alliance must be trained so that they are informed about the state and national Alliance and know how to organize and lead their county chapters to accomplish the goals that we want to achieve.



Mehry Motamen Reid

The Confluence I and II sessions sponsored by our national Alliance each year in Chicago provide excellent training for county presidents and presidents-elect. Unfortunately, here in Maryland, we are limited to sending only six members each year to these sessions. I propose that we organize our own mini-confluence session, to be held one day each year early in September. We will invite guest speakers from our own ranks and from the national Alliance to conduct workshops in their areas of expertise. While attendance at this meeting would not be mandatory, I believe that willingness to attend should be one of the criteria to be considered when each county selects its officers. Attendance by county committee chairpersons or any other interested members would be welcome and encouraged.

Now we will add the other ingredients in the amounts that will be determined in large part by the quality and dedication of our membership. These are the projects that give life and purpose to our organization: the raising of money for the AMA-ERF; the combating of domestic violence through education of the public and our support of those organizations that succor and council battered family members; the education of the public, especially elementary school children, in the evils of smoking and drug abuse; and our lobbying for an equitable and

consumer-oriented reform of health care delivery systems. No one should be denied access to state-of-the-art medical care, but the traditional doctor-patient relationship must be preserved and there must be adequate compensation for those who provide that care. As the need arises, I am sure that we will find additional projects that we can support for the betterment of our society.

Finally, we will add the spices that flavor our stew and make it palatable and fun to eat. These are the social get-togethers that are so important in fostering the enjoyment and camaraderie of our Alliance: the morning coffee klatches, luncheons, and the events that we share with our physician spouses throughout the year.

Now, let us all go into the kitchen and in each and every county prepare our own version of the basic recipe that I have outlined. Let's make the coming year a banner year for the strengthening of our Alliance and the accomplishment of our goals.

Bon appetit!

MEHRY MOTAMEN REID
1995-1996 Alliance president ■

The names of the following physicians were received too late to be included on the Doctors' Day page in the April 1995 issue of the Maryland Medical Journal:

- Myrna T. Estruch, M.D.
- Lew C. Schon, M.D.

MARYLAND

The Alliance always welcomes new members.

Alliance members support the physicians and are recognized for their contributions to health, education, and the promotion of quality health care in Maryland.

For information on becoming a member, call JoAnn Troisi at Med Chi's Alliance office.
539-0872 (Baltimore area)
1-800-492-1056 (toll free in MD)



Med Chi Bicentennial Celebrations

Med Chi has already begun planning celebration activities for its bicentennial in 1999. If you have ideas or suggestions, please call Margaret Burri or Vivian Smith at 410-539-0872 or 1-800-492-1056.

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The Medical and Chirurgical Faculty of Maryland welcomes the new members listed below. They join an organization with a 196-year history of dedicated service to improving the health and welfare of the people of Maryland. With the help and expertise of longtime members and the participation and input of new members, Med Chi can continue its proud tradition of ensuring quality health care.

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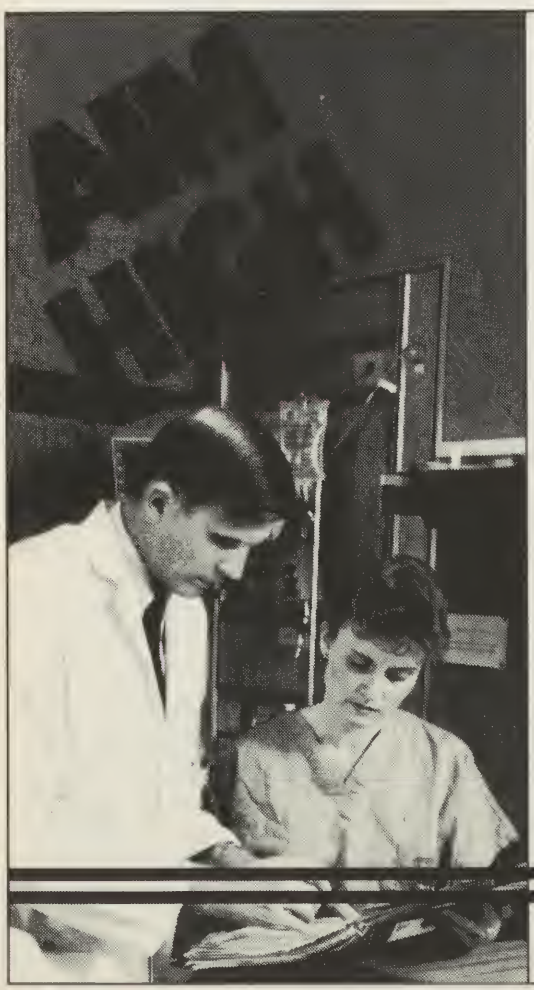
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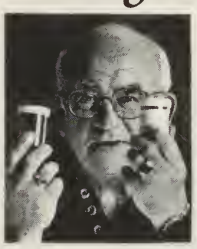
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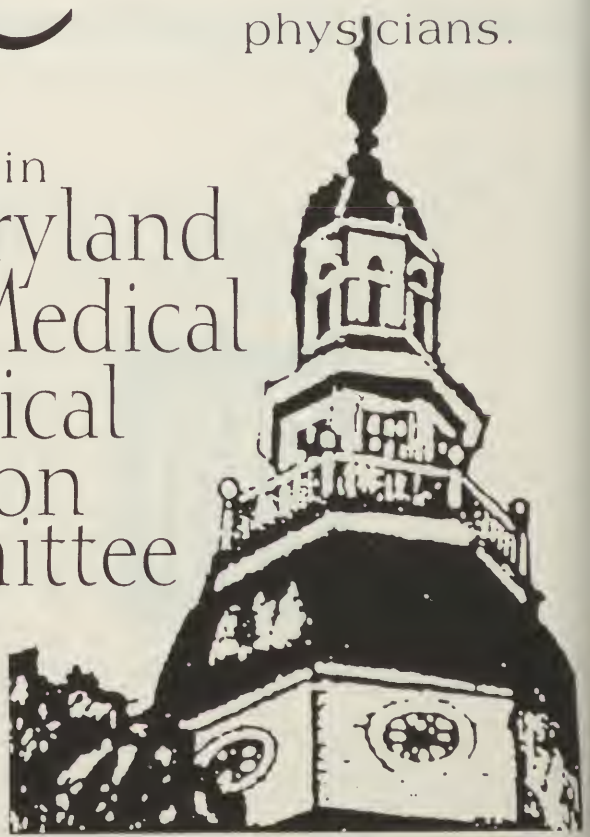
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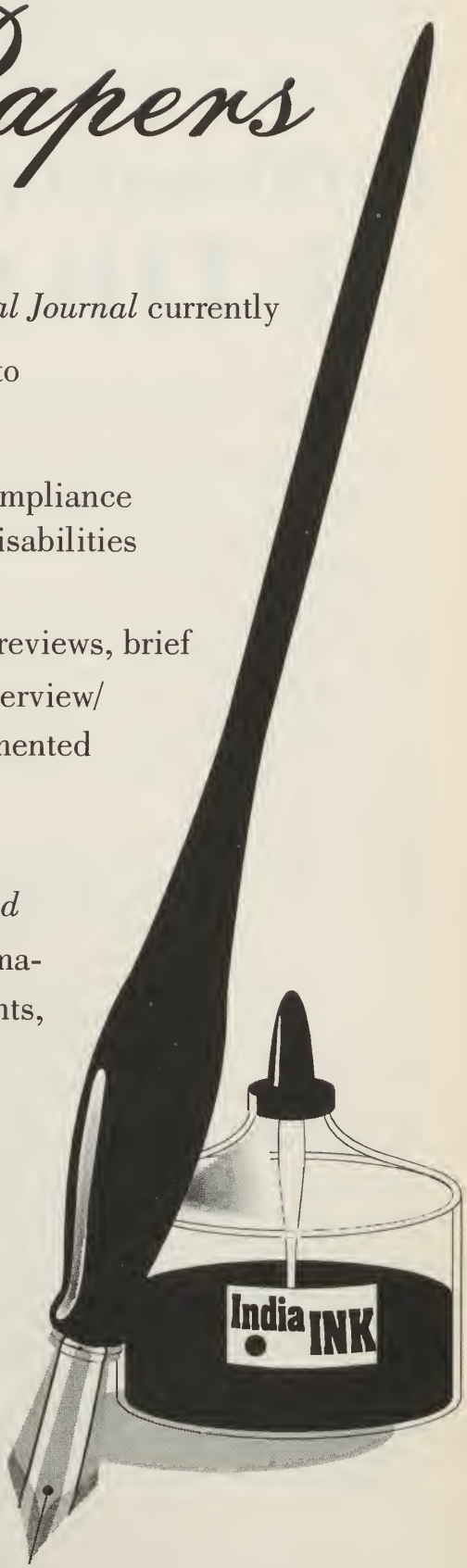
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  2. Ropes MW. Characteristics, manifestations, and pathologic findings. In: Ropes MD, ed. Systemic Lupus Erythematosus. Cambridge, MA: Harvard University Press. 1976; 50–4.

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Carroll County General, Westminster	**July 25**
Peninsula Reg. Med. Ctr., Salisbury	**July 27**
Ramada Inn, Hagerstown	**August 3**
Kent & Queen Anne's Hosp., Chestertown	**August 8**
Medical Mutual, Hunt Valley	**August 9**
Colony South Hotel, Clinton	**August 10**
Med Chi, Baltimore	**August 15**
Shady Grove Advent. Hosp., Rockville	**August 22**
Liberty Medical Center, Baltimore	**August 24**
Medical Mutual, Hunt Valley	**August 29**
Washington Advent. Hosp., Takoma Park	**August 31**

Diabetic retinopathy: a comprehensive review & update, sponsored by the Retina Institute of Maryland at the Stouffer Harborplace Hotel, Baltimore, MD. 7.5 Cat 1 AMA credits. Fee: $250/physicians; $100/other. Info: 410-337-4500. **Sept. 15**

6th Biannual gastroenterology board review course, sponsored by the George Washington University Medical Center, at the Grand Hyatt, Washington, DC. Fee and credits TBA. **Oct. 7–11**

Medical oncology board review course, sponsored by the George Washington University Medical Center, at the Ritz-Carlton Pentagon City, Arlington, VA. Fee and credits TBA. **Oct. 8–12**

Twelfth annual clinical update in pulmonary medicine CME course and luncheon, at the Trump Regency Hotel in Atlantic City, NJ, sponsored by the department of pulmonary medicine, Deborah Heart and Lung Center. CME TBA. Info: 201-385-8080. **Nov. 18**

Continuously throughout the year

Fluorescein angiography conference, sponsored by the Retina Center, Saint Joseph Hospital, Baltimore, MD, first and-third Mondays of each month; 8:00–9:00 am. Fee: none. Info: R. Classon, 410-337-4500.

The Johns Hopkins Medical Institutions

All courses at the Thomas B. Turner Building unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Medical Education, 720 Rutland Ave., Baltimore, MD 21205 (410-955-2959).

Ninth annual core content of emergency medicine: a comprehensive review, at the Stouffer Renaissance Harborplace Hotel, Baltimore, MD. $850/physicians before June 30, after $900; $800/residents and fellows before June 30, after $900. **Aug. 14–20**

Third annual airway management, Cat 1 AMA credits available. Fees: $700/physicians; $500/residents and allied health professionals; $350/one-day fee. **Sept. 8–10**

Third annual progress in hematologic malignancies and bone marrow transplantation and pediatric hematology and oncology for the pediatrician, at the Stouffer Renaissance Harborplace Hotel, Baltimore, MD. $95/physicians and nurses. **Sept. 14**

11th Birth conference: innovations in perinatal care, assessing benefits and risks, at the Hyatt Regency Baltimore Hotel, Baltimore, MD. Cat 1 AMA credits available. Fee: $300/physicians; $215/allied health professionals. **Oct. 7–8**

21st Annual topics in gastroenterology and liver disease, Cat 1 AMA credits available. Fee: $525/physicians; $275/residents and fellows; postmarked before 9/4/95, $495/physicians; $250/residents and fellows. **Oct. 11–13**

The second hands-on flexible sigmoidoscopy course, 9 Cat 1 AMA credits. Fee: $550/physicians; $400/residents, fellows. **Oct. 14**

Advanced pediatric life support courses, 21 Cat 1 AMA credits available. Fee: $575. **Nov. 13–15, June 10–12**

Continuously throughout the year

Visiting preceptorship in pediatric critical care medicine. Ongoing five-day preceptorship by appointment. 40 Cat 1 AMA/PRA credits. $600.

The department of radiology and radiological sciences offers several courses in abdominal and obstetrical ultrasound. Info: P. Williams, 410-955-3169.

Visiting physicians. Offered throughout the year for experience in the lab and participation in read-in sessions; by appointment only. 40 Cat 1 AMA/PRA credits. $500.

Johns Hopkins medical grand rounds. Accredited audiovisual continuing education series of case discussions for clinicians; 30 topics per year in five bimonthly programs. Individual and group subscriptions. 40 Cat 1 AMA/PRA credits. Info: 410-955-3988.

Johns Hopkins sports medicine grand rounds. Accredited continuing education series of case discussions by a different presenter on the first Thursday of each month. Info: Carol Kelly, 410-383-0600.

University of Maryland

For each course, additional information may be obtained by contacting the Program of Continuing Education, University of Maryland School of Medicine, Room 14-011, BRB, 655 W. Baltimore St., Baltimore, MD 21201 (410-706-3956) or by calling the phone number listed after a specific program. FAX 410-706-3103.

Managing emergency medical services, at the University of Maryland Baltimore County (UMBC). Sponsored by the UMBC Department of Emergency Health Services and the Maryland Institute for Emergency Medical Services Systems. Info: Dr. Richard Bissell, 410-455-3776. **July 2–28**

Celiac disease—the dark side of the gastrointestinal planet, at the R Adams Cowley Auditorium, University of Maryland Med. Ctr., 10 Cat 1 AMA credits. Fee: $50. Info: Vicky Roach, 410-328-0812. **July 14–15**

1995 Advanced pre-operative evaluation and planning for complex deformities, at the Pikesville Hilton Inn, Baltimore, MD. 25 Cat 1 AMA credits, 6 optional. Fee: $450. Info: Steven Kaniecki 410-448-3394. **Sept. 16–19**

7th annual Maryland conference—AIDS: a challenge to primary care: science, practice, art, at the Baltimore Convention Center, Baltimore, MD. 9 Cat 1 AMA credits. Fee: $240. Info: Sylvia Scherr, 410-328-5759. **Oct. 5–7**

Endocrinology and metabolism update for the practicing physician—1995, at the Pier 5 Clarion Inn, Baltimore, MD. 10 Cat 1 AMA credits. Fee: $185. Info: John Wilber, M.D., Connie Ball, 410-328-2515. **Nov. 3–4**

PHYSICIAN'S RECOGNITION AWARD

During April 1995, the physicians listed below received the American Medical Association (AMA) Physician's Recognition Award. Established in 1968, the award's purpose is to encourage physician participation in continuing medical education and to recognize those physicians who have voluntarily completed programs of continuing medical education.

Steven B. Allen, M.D.
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John O. Colonna, M.D.
Craig R. Dufresne, M.D.
Edmund J. Forte, M.D.
John A. Galotto, M.D.
Edito C. Galvez, M.D.
William B. Gamble, M.D.
Bernard A. Heckman, M.D.
Alan L. Heine, M.D.
Richard S. Kaplan, M.D.
Donald F. Leon, M.D.
Iradj Mahdavi, M.D.
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Kevin E. McGovern, M.D.
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David V. Nasrallah, M.D.
Susan E. Otero, M.D.
Julian J. Platt, M.D.
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Glen I. Reeves, M.D.
Ralph E. Rickel, M.D.
Robert J. Rothstein, M.D.
Donald I. Saltzman, M.D.
Deepak Seth, M.D.
Kristi D. Silver, M.D.
Joseph J. Wallace, M.D.
Linda A. Williams, M.D.
Irving D. Wolfe, M.D.
Kim B. Yancey, M.D.

University of Maryland (continued)

Continuously throughout the year

Optimal dosing in chemotherapy: adoptive control with carboplatin, video tape, monograph and test. Expires March 1996, 3 Cat 1 AMA credits. Info: 212-924-3044.

U.S. medical costs and values: primary prevention versus end stage treatment, monograph and test. Expires Aug. 1996, 2 Cat 2 AMA credits. Info: 908-281-3772.

Lipid management for coronary heart disease: a proven hypothesis, audio tape and test. Expires Aug. 1996. 1 Cat 2 AMA credit. Info: 609-497-9743.

Academic rounds and conference, each academic department within the school of medicine has a series of lectures and/or seminars available to physicians. Cat 1 AMA credits available. Info: 410-706-3956.

The National Museum of Civil War Medicine will hold its annual Civil War Medicine Conference at Hood College in Frederick, Maryland, Friday, August 4 through Sunday, August 6, 1995. At least 15 speakers will address topics such as the Chimborazo Hospital complex in Richmond and the type and nature of gunshot wounds at Gettysburg. To obtain more information about the conference, contact the Museum of Civil War Medicine, P.O. Box 470, Frederick, Maryland 21705; telephone 301-695-1864; fax 301-695-6823.

PHYSICIAN PLACEMENT SERVICE

The Medical and Chirurgical Faculty of Maryland maintains a Placement Service for the convenience of Maryland physicians, hospitals, and communities in search of candidates for positions available in our state. A detailed description of such opportunities should be forwarded to:

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Baltimore, MD 21201
410-539-0872
1-800-492-1056

Physicians wishing to locate in Maryland are invited to submit a résumé to be kept on file with the Physician Placement Service. Candidates are requested to inform the Faculty when they are no longer available for consideration opportunities in Maryland.

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Department of Health and Mental Hygiene

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Community Health Surveillance & Labs Admin

Ebenezer Israel, M.D., M.P.H., Director
Epidemiology and Disease Control Program

DHMH Maryland Department of Health & Mental Hygiene

EPIDEMIOLOGY AND DISEASE CONTROL PROGRAM

201 West Preston Street, Baltimore, Maryland 21201 (410) 225-6700

July, 1995
Selected Communicable Disease in Maryland in 1994

This report describes the epidemiology of selected communicable diseases reported to the Epidemiology and Disease Control Program in 1994. It is based on data collected through the communicable diseases reporting system, a mostly passive system that receives reports from health care providers and laboratories, and from other sources.

Each week the communicable disease data collected by the 24 local health departments is electronically transmitted to the Division of Communicable Disease Surveillance at the DHMH Epidemiology and Disease Control Program. At DHMH the data is combined, edited, reformatted, and then transmitted to the Centers for Disease Control and Prevention (CDC) in Atlanta, Georgia, where it becomes part of the CDC's Morbidity and Mortality Weekly Report (*MMWR*).

An important change has taken place in Table 1 compared to the data presented in recent years. This year, Table 1 summarizes cases ***reported in*** 1994. In prior years, cases were summarized by ***onset date*** in the reporting year. This change has been made primarily so that local health departments can compare the yearly data to reports they have made throughout the year, and so that the Maryland summary parallels the CDC's *MMWR* summary of cases ***reported in*** that year. Making this change for the 1994 data means that some of the cases reported in 1994 were also included in the 1993 report. Cases with onset in 1993 represent approximately 10% of those cases reported in 1994.

In this report the number in parenthesis after the title of each disease indicates the number of cases reported in Maryland in 1994. Below the disease name are the incidence rates in Maryland and in the United States. The rates in Maryland are based on the 1994 population estimates (Maryland Office of Planning - 1994 Population Estimatess by Age, Sex, and Race. Preliminary Revision June, 1995). The incidence rates in the United States are based on the 1994 population projection, obtained from the U.S. Bureau of the Census, and the cumulative number of cases reported to the *MMWR* system in 1994 (CDC. *MMWR*, January 6, 1995, Vol. 43, Nos. 51 & 52).

The prompt, accurate, and complete reporting by physcians, other health care providers, laboratories, etc., is extremely important for achieving our goal to describe and control communicable diseases in Maryland. We gratefully acknowledge the cooperation of all those who contributed to

communicable disease surveillance in Maryland and the United States by reporting, investigating, and acting to control these diseases. We would especially like to acknowledge Dr. Christina Lazar who has retired this year after serving as Chief of the Division of Communicable Disease Surveillance for 15 years, and Ms. Anne Jones, who coordinated the data entry and editing.

BOTULISM (1)
0.02/100,000 (U.S. 0.05/100,000)

The single case of infant botulism reported in 1994 had onset in 1993, and was described in the 1993 summary.

ENCEPHALITIS, PRIMARY AND POST-INFECTIOUS (33)
0.7/100,000 (U.S. 0.3/100,000)

The incidence rate per 100,000 population in 1994 (0.7) increased slightly over the rate in 1993 (0.5). The number of cases by county is shown in Table 1. The highest incidence rates occurred in Allegany, Calvert, and Garrett counties. Fifteen cases (53.6%) of the 28 cases with known onset date had onset of illness in June, July, and August.

The male to female ratio was 1.2:1; the ratio of whites to blacks was 4.5:1. The age of patients ranged from three days through 95 years (median 30 years); 2 cases (6.1%) were less than one year of age.

Herpes viruses (6 cases, including 3 post-varicella), cytomegalovirus (1), caused or were suspected to have caused 7 of the cases; the cause for the rest was not identified. Three of the 27 patients for whom outcome was known died for a case fatality rate of 11.1%. No arboviral encephalitis was reported for 1994.

GONOCOCCAL INFECTONS (16,823)
[336.0]/100,000 (U.S. 153.9/100,000)

Reported gonococcal infections increased by 22% over the 1993 level (13,832). This is the first increase since 1990 when 23,446 cases were reported. The distribution of cases by jurisdicton is shown in Table 1.

Baltimore City noted a 21% increase from 1993, while the counties (excluding Baltimore City) increased by 24%. Sixty four percent of cases were in Baltimore City residents, accounting for the highest rate per 100,000 (1535.4) in the State. Counties with the highest rates were: Wicomico (611.7), Dorchester (499.6), Prince George's (348.1), and Somerset (316.1). Maryland and U.S. incidence rates are shown in Figure 1.



Fig 1. Gonococcal Infection. Incidence Rates in Maryland and the United States, 1985-1994.

The age distribution is similar to previous years in that 81% of the cases were reported in the 15-34 year-old age group.

Among the 10,667 cases for whom race was reported, 92% occurred in African Americans.

Table 1. Cases of Selected Notifiable Diseases Reported in Maryland in 1994 by County

DHMH
Maryland Department of Health and Mental Hygiene

Jurisdiction	Population	Infectious Parotitis (Mumps)	Pertussis	Rubella (German Measles)	Rubeola (Measles)	Hepatitis A	Hepatitis B	Hepatitis NANB	Hepatitis, Unspecified	Encephalitis	Haemophilus influenzae Disease	Meningococcal Disease	Meningitis, Bacterial	Meningitis, Viral	Salmonellosis	Typhoid Fever	Shigellosis	AIDS	Gonorrhea	Syphilis, Primary and Secondary	Syphilis, Congenital	Tuberculosis	Lyme Disease	Rocky Mountain Spotted Fever	Animal Bites	Rabies, Animal
Allegany	73,867		2			1	3	1		4	2			4	19		1	3	24	1		2	1		255	26
Anne Arundel	456,172	5	6			18	30			2	5	1	16	13	84	2	10	95	328	18		15	26	3	1,059	20
Baltimore City	703,057	8	6			38	106	2	2	2	16	9	57	16	229	1	87	1529	10,802	192	13	105	21		1,367	13
Baltimore Co.	711,783	12	9		2	22	48	5		7	16	5	22	33	147	3	25	193	679	21	2	35	90		653	41
Calvert	62,179						1			3	3	2	2	4	6		1	6	46	1		3	6		214	14
Caroline	28,719	1				2	1				1		4	3	16			6	52			2	13		65	7
Carroll	136,443	2	7			11	3				4		3	5	25			7	29			3	8	2	417	22
Cecil	77,037		2			2	2				2	1	1		13			6	41	1		2	41		422	24
Charles	109,296	1				3	7			2	2		4	6	25		12	11	173	4		2	15	3	397	4
Dorchester	30,424					2	1						1	3	24			9	152	5		1	5	2	158	5
Frederick	171,275					1	2	1	1		1		4	10	25		1	23	133			10	1	2	455	58
Garrett	29,371		1					0		1		1	1		1				3						112	18
Harford	201,985	2	1			6	5	0			5	2	1	13	40		8	36	59	2		5	28		415	27
Howard	212,975	2	1			15	6	0			4	1	4	9	48	2	7	23	101			4	13	2	381	15
Kent	18,687	2						0			1				6			4	49				19		88	14
Montgomery	802,722	16	11		1	32	27	1		2	7	3	19	52	171	4	94	189	436	7		80	23		1,365	25
Prince George's	764,052	9	3			17	91	2	5	4	15	6	27	50	175	2	68	353	2,660	62	6	75	16	1	1,102	30
Queen Anne's	36,070					1	1			1	2				7		2	7	13	2		4	25		129	21
Saint Mary's	80,324	4	1			3	4			1			1	6	18		1	5	171			3	6	5	187	6
Somerset	23,727					1	5						4		9		1	7	75	2		2	1		107	58
Talbot	32,015					5	2				1			2	13		2	9	85	3	1	0	10	1	114	9
Washington	126,600						6			4		1	1	12	25			19	119			4		1	227	16
Wicomico	78,474	1	1		1	16	2	10				2	1	4	37		3	36	480	4		3	10		538	9
Worcester	39,015		2			2	1	1					2		14			11	113	1		3	2		169	38
Not Stated																		221								
Maryland Total	5,006,269	65	53	0	4	198	354	23	8	33	87	34	175	245	1,177	14	323	2,808	16,823	326	22	363	380	22	10,396	520
Maryland Totals for Prior Years	1993	85	167	2	4	184	288	16	5	25	64	50	41	257	1,028	8	453	1,617	13,832	393	36	417	207	23	10,349	624
	1992	84	52	5	17	254	388	31	9	22	81	31	165	223	1,021	7	430	1273	16,513	590	62	442	185	16	10,676	553
	1991	236	61	1	178	258	387	45	20	27	40	35	166	333	1,262	8	258	841	21,464	1,016	54	451	283	22	9,927	579
	1990	1136	90	3	204	866	545	45	13	27	57	45	141	266	1,251	33	249	788	23,446	1,136	81	384	238	20	9,690	468

Table 1. Cases of Selected Notifiable Diseases Reported in Maryland in 1994 by County

Continued

DHMH
Maryland Department of Health and Mental Hygiene

Jurisdiction	Population	Amebiasis	Anthrax	Botulism	Brucellosis	Campylobacteriosis	Cholera	Giardiasis	Kawasaki Syndrome	Legionellosis	Leprosy	Leptospirosis	Listeriosis	Malaria	Mycobacteriosis, Atypical	Newborn Infection	Plague	Poliomyelitis	Psittacosis	S. typhi Carrier	Tetanus	Trichinosis	Tularemia	Typhus, Murine	Vibrio (Non-O1) Infection	Yersiniosis
Allegany	73,867					8				1			1		2											1
Anne Arundel	456,172				1	23		8	7	5			4	6	65	3		1			1		1			1
Baltimore City	703,057					59		36	1	8			6	5	454	19			1							11
Baltimore Co.	711,783								3	25			4	5	51	10										
Calvert	62,179													1	3											
Caroline	28,719					2									3	1										
Carroll	136,443					7		2	1	9			1		7	2										
Cecil	77,037												1	1	5											
Charles	109,296					10									3	3										
Dorchester	30,424									1																
Frederick	171,275					1		1	1	11				1	19	2										
Garrett	29,371														1				1							
Harford	201,985					8			1	3				1	9	3										
Howard	212,975					8		13	2	2				3	8	2								1		1
Kent	18,687														1					1						
Montgomery	802,722	6				24	1	14	8	3				25	102	2				1					1	
Prince George's	764,052	4		1		19		16	11	10		1	2	35	111	26										4
Queen Anne's	36,070					1		2							2											
Saint Mary's	80,324	1				1		6	1	1					2											
Somerset	23,727					1									10											
Talbot	32,015					1									3											
Washington	126,600					2				3					8	1										
Wicomico	78,474	1				23		7							55	3										
Worcester	39,015					6		3							7											
Not Stated															117											
Maryland Total	5,006,269	12	0	1	1	204	1	108	36	82	0	1	19	83	1048	77	0	1	2	2	1	0	1	1	1	18
Maryland Totals	1993	9		1		141		107	30	52		1	9	57	695	133		1	1	1	2				1	24
for	1992	10		1		150	3	69	26	39			25	61	577	136			2	4		3		1	5	23
Prior Years	1991	9				119	4	90	17	34	5		2	62	507	84		1	5	2	1		2		2	28
	1990	8		7		128		58	17	48	1	1	5	57	473	30	1		2	1					6	39

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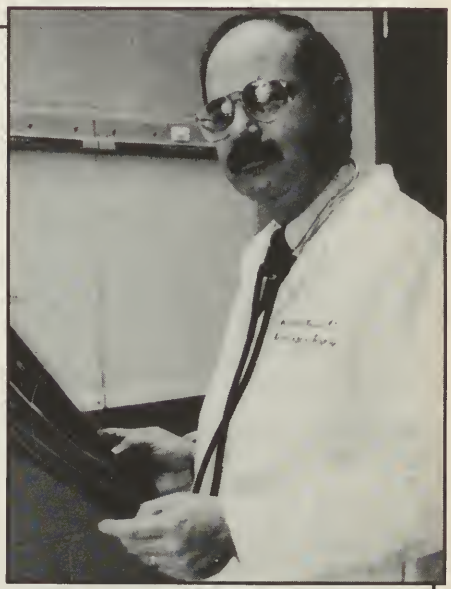
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Results of a 21-year follow-up of more than 10 000 male Israeli government workers indicate that **even light physical activity on a less-than-daily basis may be inversely related to coronary heart disease (CHD) and all-cause mortality.** The inverse relationships persisted after adjustment for confounders such as age, systolic blood pressure, cigarette smoking, total and high-density lipoprotein cholesterol levels, body mass index, and medication use (*Arch Fam Med* 1995;4:323-329). Although these findings are consistent with those of numerous other studies, an accompanying editorial (*Arch Fam Med* 1995;4:309-310) points out one of the study's unexpected findings. The population-attributable risk percentages—which quantify the percent of reduction in mortality due to CHD in the population if the given risk factors were completely eliminated—indicate that after controlling hypertension, the next greatest risk reduction factor is adopting a nonsedentary lifestyle. According to the study data, the reduction would be greater than that produced by controlling everyone's cholesterol levels or by eliminating smoking.

A double-blind, placebo-controlled, two-year study of the effect of a daily supplement of 400 IU vitamin D_3 **in women aged 70 and older** not taking calcium supplements indicates **vitamin D may increase bone mineral density at the femoral neck** (*J Clin Endocrinol Metab* 1995;80:1052-1058). Although supplementation did not appear to alter bone density at the femoral trochanter or distal radius, the authors conclude that vitamin D supplementation may nevertheless be a safe method to help prevent hip fractures in the elderly.

Obstructive sleep apnea syndrome has been reported to occur primarily in men and massively obese women. A retrospective case-control study (*Ann Intern Med* 1995;122:493-501), however, indicates **sleep-disordered breathing may be underdiagnosed in women.** Study subjects were 334 women aged 18 and older (mean, 51.6 ± 14.1) who had been diagnosed by sleep laboratory measures as having upper airway sleep-disordered breathing. Control subjects included 60 women with insomnia and 100 men with sleep-disordered breathing. Of the study subjects, 48% were premenopausal, 26% were menopausal, and 26% were postmenopausal. Most were not overweight. Approximately 11% had a respiratory disturbance index of less than 5 and were significantly younger, had a smaller neck circumference, and had a lower body mass index than subjects with a respiratory disturbance index of more than 5. In 45%, there were abnormal maxillomandibular features (e.g., triangular chin, overjet or overbite, high hard palate). Dysmenorrhea and amenorrhea were reported in 43% of the premenopausal women with disordered breathing and in only 13% of the women with insomnia. Perhaps the most interesting study finding is that the **menstrual disturbances in the disordered breathing group disappeared after treatment with nasal continuous positive airway pressure.**

Data from the national Birth Defects Monitoring Program indicate **the rate of reported cases of fetal alcohol syndrome** (FAS)—the most severe expression of in utero alcohol damage to the fetus—**identified among newborns in the United States from 1979 to 1992 increased approximately fourfold.** The rate for 1993 was more than sixfold higher than that for 1979 (1.0 per 10 000 births). The increase may reflect a true increase in the number of infants with FAS or an increase in the awareness and diagnosis by primary care physicians of FAS in newborns (*MMWR Morb Mortal Wkly Rep* 1995;44:249-253.)

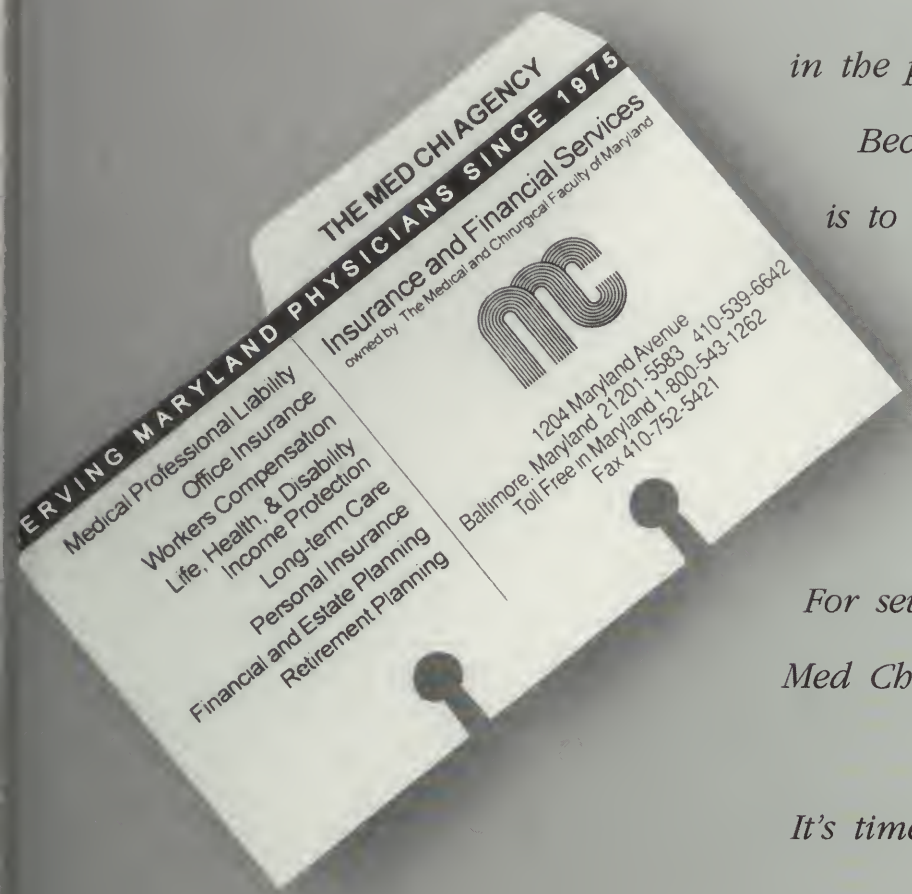
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Due to concern that there may be gender-based differences in the management of patients who present with signs or symptoms of myocardial ischemia, the National Heart, Lung, and Blood Institute recommended in 1992 that data from existing clinical trials and registries be analyzed to compare a number of features of coronary heart disease manifestation and treatment in men and women. **In a study based on data from the Coronary Artery Surgery Study registry**, the rates of coronary artery bypass graft surgery and 15-year survival after initial medical or surgical treatment were compared for men and women. Results indicate that, even after adjusting for clinical and angiographic variables, **bypass surgery rates did not differ between men (75%) and women (72%) and there were few differences in the 15-year survival rate.** With initial medical treatment, the survival rate was 50% for men and 49% for women; with initial surgical treatment, the rates were 52% for men and 48% for women (*J Am Coll Cardiol* 1995;25:1000-1009).

Due to conflicting data on possible health risks associated with vasectomy, and the fact that little data are available on the annual number of vasectomies and the medical practice of vasectomy in the United States, the Association for Voluntary Surgical Contraception and the Centers for Disease Control conducted a retrospective survey of urology, general surgery, and family practices (*Am J Public Health* 1995;85:644-649). Results indicate that **in 1991, approximately 493 000 vasectomies were performed, for a rate of 10.3 procedures per 1000 men aged 25 to 49.**

Results of a small study published in the *Lancet* (1995;345:292-292) suggest that **circumcision without anesthesia may have a pronounced effect on future perception of and response to pain.** Study subjects included 30 circumcised and 12 uncircumcised infants. Compared to the latter, the circumcised babies cried longer and had higher behavioral pain scores after being vaccinated at age 4 to 6 months.

Gentlemen, if you ever need extra incentive to fight the middle-age bulge that tends to "slip" onto our bodies as time marches on, read "Physical activity, obesity, and risk for colon cancer and adenoma in men" (*Ann Intern Med* 1995;122:327-334). **Investigators** from the Harvard schools of medicine and public health **prospectively surveyed 47 000 male health professionals for the development of colon cancer over a six-year period.** Physical activity was calculated in metabolic equivalents (METs); as an example, one hour of running per week generates 10.2 MET-hours. Anthropometric variables including waist-to-hip ratio to assess relative fat distribution and waist circumference to estimate total abdominal fat were surveyed. **Study subjects in the highest quintile** (20%) **for average energy expenditure** (mean 46.8 MET-hours per week) **had less than half the incidence of colon cancer as sedentary colleagues in the lowest exercise group** (p value for trend equaled 0.002). Relative risk for colon cancer was 2.56 times higher for study subjects with waist circumference greater than 43 inches than for study subjects whose waist size was less than 35 inches. The study provides further grounds for encouraging your male patients and colleagues to increase their level of physical activity and avoid those double chocolate fudge sundaes.



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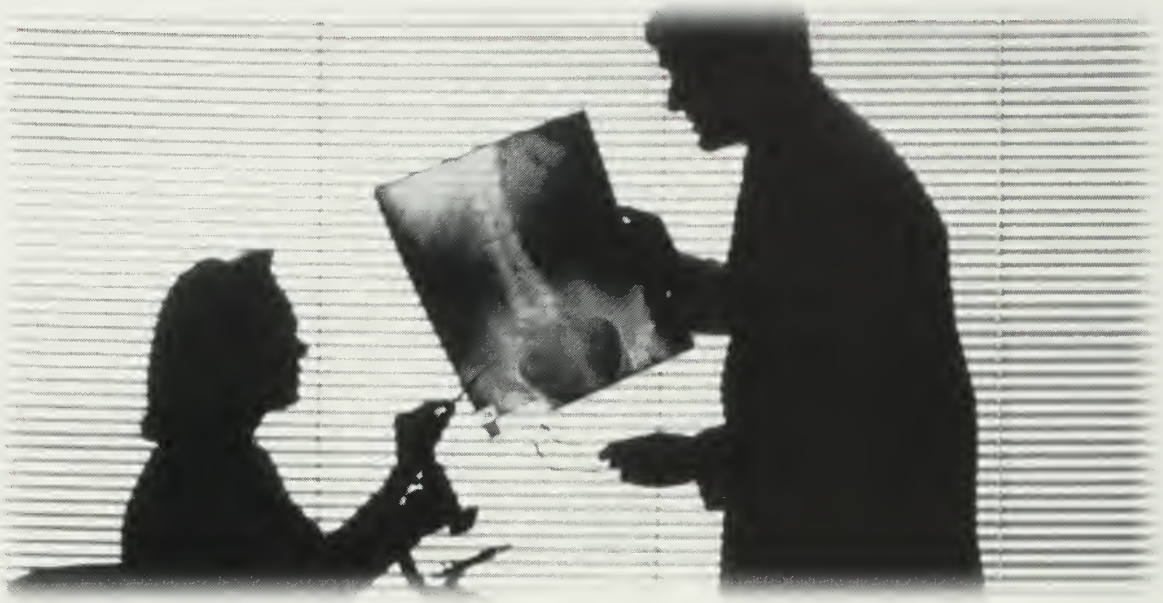
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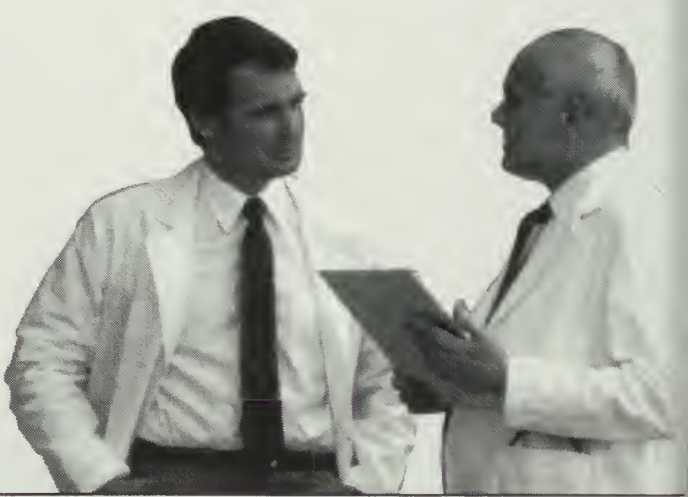
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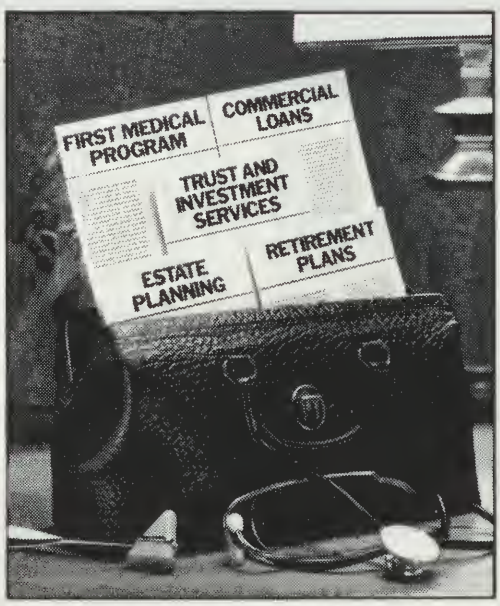
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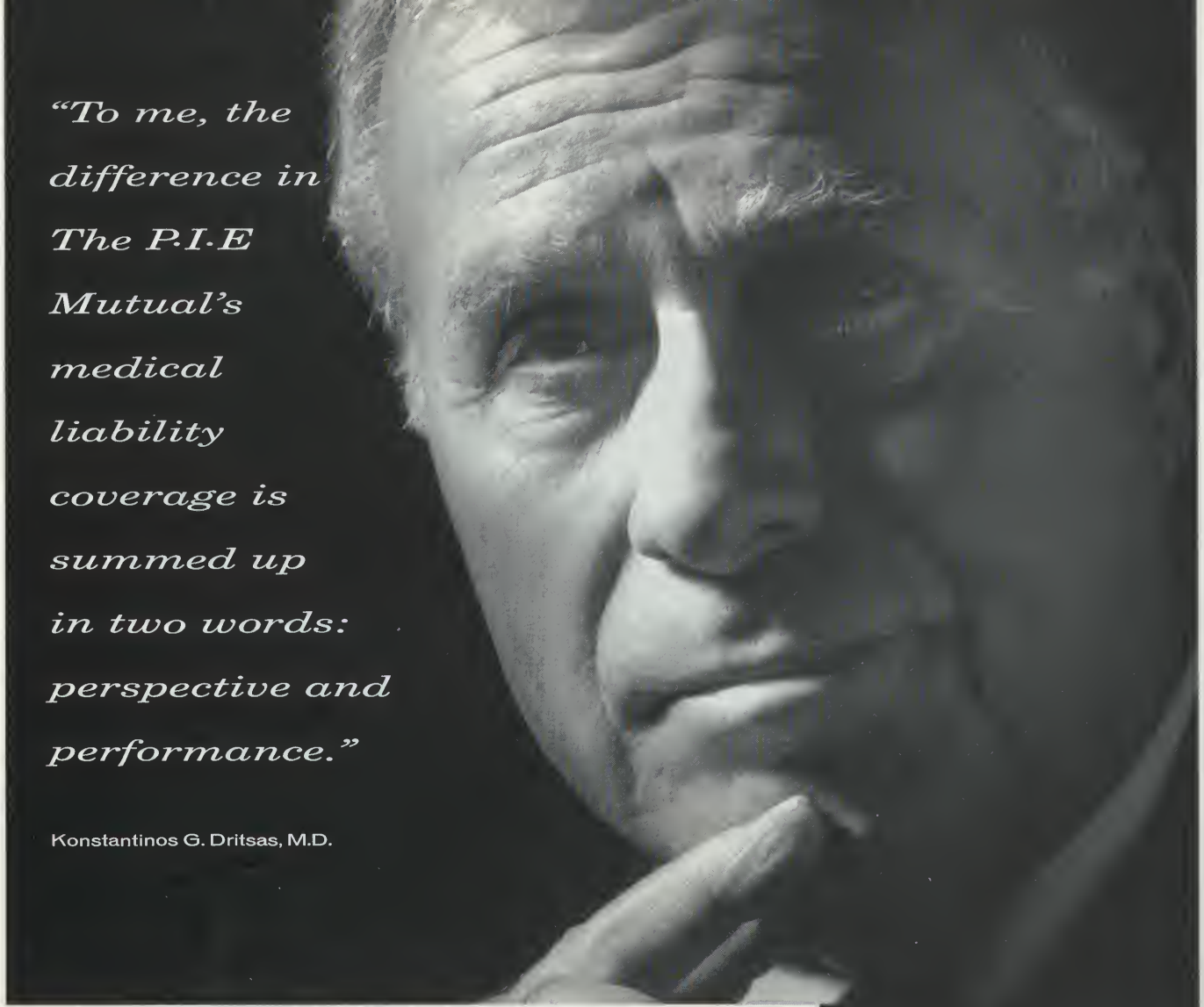
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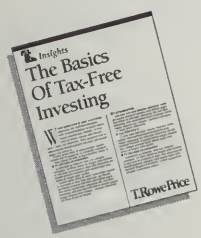
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1995 Med Chi Semiannual Meeting - Preliminary Program

The preliminary program and a registration form for the 1995 Med Chi Semiannual Meeting immediately follows this issue of the *Chief Executive Officer's Newsletter*. The semiannual meeting will be held Friday, September 8, through Sunday, September 10, at the Princess Royale Oceanfront Hotel and Conference Center, Oceanfront at 91st Street, Ocean City, Maryland.

NOTE: DON'T FORGET TO MAKE YOUR HOTEL RESERVATIONS — DEADLINE IS AUGUST 8TH. Med Chi has reserved a block of rooms at the following group rates: $126 per night for a single/double occupancy oceanview suite and $169 per night for a single/double occupancy oceanfront suite (tax and incidentals not included). Two- and three-bedroom condos are also available. To reserve a room, call the Princess at 410-524-7777 or 1-800-4ROYALE (1-800-476-9253), and tell them you will be attending the Med Chi meeting.

AllNet

Med Chi has had numerous inquiries concerning the marketing of an organization known as AllNet. All of the information which we have accumulated from physicians concerning this organization has been forwarded to the Attorney General's office for investigation since Med Chi has not been able to find out exactly what services AllNet provides for its membership or what type of network it is. If you have any information concerning AllNet, please contact Joyce Yensen, Legal Assistant, Med Chi, at 1-800-492-1056 or 410-539-0872.

Medical Records Copying Charges

Physicians and patients are calling Med Chi to inquire about charges for medical records. Current Maryland law provides that a physician may require payment for preparing, copying, and mailing the medical record. The law authorizes a health care provider to charge:

a. a fee for copying and mailing not exceeding 50 cents for each page of the medical record; in addition to
b. a preparation fee not to exceed $15 for medical record retrieval and preparation; and
c. the actual cost for postage and handling of the medical record.

Controlled Dangerous Substances

The Maryland Court of Appeals ruled that the General Assembly does not have to add drugs listed as controlled dangerous substances under federal law to the Maryland Code to convict someone on state drug charges. Under Art. 27, §278(c) of the Maryland Code, drugs that become controlled dangerous substances under federal law become controlled under state law unless the Department of Health and Mental Hygiene objects.

The case which brought this issue to the Court's attention was Abraham Arah Warsame v. State of Maryland and the issue was whether a substance con-

trolled in Maryland by virtue of being a controlled dangerous substance under federal law, remains controlled despite the fact that the substance has never been listed in the Maryland schedule of controlled dangerous substances.

Medicare Update

TrailBlazer Health Enterprises, Inc.

1. Drug Pricing

   The June 15, 1995, issue of *TrailBlazer Medicare Part B* contains information about the new method of pricing that will change the reimbursement rate for drugs, effective for claims submitted on or after July 15, 1995. Please refer to this issue for detailed information about payment based on the median Blue Book price.

2. Non-Allowed Amount on EOMB

   Providers have requested that a "non-allowed amount" column appear on the Explanation of Medicare Benefits (EOMB) statements. TrailBlazer cannot alter its present format to allow for this column due to limitation of space.

General Information

1. Excluded Providers

   Section 1862(e)(1) of the Social Security Act precludes payment for services provided by an individual or entity excluded from the Medicare program or at the medical direction or on the prescription of a physician excluded from the Medicare program. If a provider submits services prescribed by an excluded physician, the first claim submitted may be paid; however, the provider will be notified of the physician's exclusion from the Medicare program and subsequent claims submitted for services prescribed by the excluded physician will be denied.

2. Item 29, HCFA-1500 Claim Form

   The amount filled in on Item 29 of the HCFA-1500 claim form should be the amount paid by the patient for covered services on the submitted charges.

3. RUC

   The Relative Value Update Committee (RUC) has been working with HCFA since 1991 to refine work RVUs for existing codes and to establish work RVUs for new codes. The committee consists of representatives from the AMA and from major specialty societies. This committee offers another way for physicians to be heard with regard to their concerns about work RVUs.

Xact Medicare Services

1. Drug Fees

   The June 1995 edition of Xact's *Medicare Report* shows the fees for drug procedure codes which have been revised to reflect changes in the average wholesale price (AWP). The new fees will be effective for dates of service on or after July 17, 1995.

2. Electronic Services

Xact has produced a "Quick Reference Card" for Medicare Electronic Services. This reference card appears in the June 1995 edition of *Medicare Report* as a tear out.

Medical Mutual Receives Upgraded Rating

The Medical Mutual Group (which includes Medical Mutual Liability Insurance Society of Maryland and Mid-Atlantic Medical Insurance Company) has received, from A.M. Best Company, a rating upgrade from B++ (very good) to A-(excellent). The ratings will appear in the *1995 Edition of Best's Insurance Reports, Property/Casualty*, due out later this summer.

"Sustaining the Medical Marriage" Presentation to be Held

The American College of Emergency Physicians, Maryland Chapter, the Med Chi Alliance, and the Med Chi Physician Rehabilitation Program are co-sponsoring "Sustaining the Medical Marriage," presented by Michael F. Myers, M.D., on September 14, 1995, 7:00 p.m. to 9:00 p.m., at the Belvedere Hotel - Charles Room. Refreshments will be provided.

Dr. Myers is the author of *Doctors' Marriages; A Look at the Problems and Their Solutions;* director of the Marital Discord Clinic, St. Paul's Hospital, Vancouver, BC; and clinical professor of psychiatry at the University of British Columbia.

The presentation is free for physicians and their significant others, but seating is limited and RSVP is required. For reservations, please call Lori Robinson at 410-962-5580 or 800-992-7010.

Physician Rehabilitation Program is Holding its Sixth Annual Conference

The Sixth Annual Conference — Diagnosis and Treatment of Addictive and Mental Health Disorders in Specialty Populations — is being held Saturday, October 21, 1995, at the Med Chi Faculty Building. Topics will include mental health disorders in the elderly, in women, in the developmentally disabled, in the minority patient, in the hearing impaired, and in the pregnant patient; implications and enforcement of Americans with Disabilities Act; caring for a physician patient; and a case review panel of addiction experts.

Registration fees are $60 for Med Chi members; $100 for nonmember physicians/Ph.D.; $40 for allied health professionals; and no charge for medical students or medical residents. For additional information, or to obtain a registration form, call 410-962-5580 or 800-992-7010.

AMA Announces Political Education Grassroots Conference

The American Medical Association's 1995 Political Education Grassroots Conference is scheduled for September 27-28 at the Mayflower Hotel in Washington, DC. The two-day conference includes briefings on the latest legislative, regulatory, and political activity occurring in Washington, an opportunity for attendees to visit one-on-one with their Representatives and Senators, and the opportunity to learn about the latest and most effective written and electronic grassroots communication techniques.

This conference is a must for those in the medical community involved or interested in actively participating in grassroots activities on behalf of the AMA. To register or obtain more information, call the Division of Political Education at 202-789-7464.

Calling All Physician Photographers

The *Maryland Medical Journal* is seeking photographs to be considered for use as covers for future issues. Anyone interested in submitting photographs should first contact Mary Ann Ayd at 410-539-0872 or 800-492-1056 for specifications.

Participants Needed for Low Back Pain Study

The University of Maryland Medical Center is looking for people between the ages of 18 and 55 who have been suffering from back pain, to take part in a study. Participants must have had back pain for at least six months. The one-year study is designed to look at different forms of treatment for back pain including Tai Chi, relaxation exercises, and meditation. For more information, call 410-706-3733.

Baltimore City Medical Society Foundation Awards Students

The Baltimore City Medical Society Foundation, a philanthropic organization dedicated to assisting medical school students achieve their ambitious goal of becoming physicians, awarded $29,500 in scholarships to seven medical school students. Scholarships are provided to medical school students from Baltimore City and to Maryland residents enrolled at Johns Hopkins or University of Maryland. The following individuals received the scholarships: Timothy M. Beittel of Baltimore at University of Rochester School of Medicine in New York; Patricia C. Richardson of Baltimore at Loma Linda University School of Medicine in California; from Johns Hopkins — Andrew L. Chen, Alpa N. Laheri, and Scott M. Needle; and from University of Maryland — Lisa N. Hawes and David S. Heydrick.

Erratum

In the minutes of the meeting of the House of Delegates, Sunday, September 11, 1994, published in the November 1994 *MMJ*, Resolution 17-94, Single/Payer System, should have read:

> RESOLVED, That the Medical and Chirurgical Faculty of Maryland continue to explore all health systems options, <u>including single payer system</u>, for...



Angelo J. Troisi, F.A.C.H.E.
Chief Executive Officer

1995 Semiannual Meeting

of the Medical and Chirurgical Faculty of Maryland

Preliminary Program

Working Together— Primary Care for Specialists; Specialty Care for Primary Care Physicians



Friday, September 8 -
Sunday, September 10, 1995
Princess Royale Oceanfront Hotel and
Conference Center, Ocean City

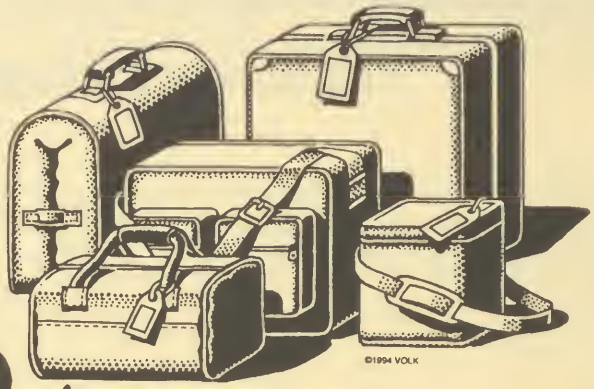
CME Information

The Medical and Chirurgical Faculty of Maryland is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education.

The Medical and Chirurgical Faculty of Maryland designates this continuing medical education (CME) activity for 26 hours in Category 1 of the Physician's Recognition Award of the American Medical Association. Because some educational sessions will be presented concurrently, the maximum number of credits which can be earned by a physician attending this meeting is 16 CME credits.

Committee on Scientific Activity Members

James P. Flynn, M.D., Chairperson
Benjamin V. Del Carmen, M.D.
Marion Friedman, M.D.
Anita M. Holloway, M.D.
Myron I. Murdock, M.D.
Stanley R. Platman, M.D.
Howard M. Silby, M.D.
Kerry J. Thompson, M.D.
John B. Umhau, M.D.



Princess ROYALE

Hotel Information

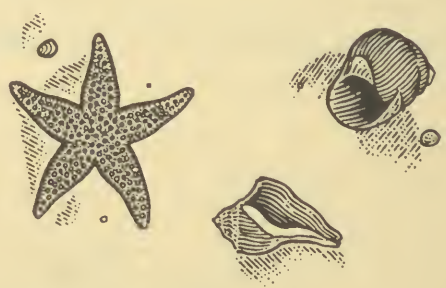
The Princess Royale Oceanfront Hotel and Conference Center is located Oceanfront at 91st Street. Med Chi has reserved a block of rooms at the following group rates: $126 per night for a single/double occupancy oceanview suite and $169 per night for a single/double occupancy oceanfront suite (tax and incidentals not included). Two- and three-bedroom condos are also available. To reserve a room, call the Princess at 410-524-7777 or 1-800-4ROYALE (1-800-476-9253), and tell them you will be attending the Med Chi meeting. Please reserve now - **reservation deadline is August 8, 1995**, but rooms may fill prior to this date.

Check-in time at the Princess is 4:00 p.m.. Guests arriving before 4:00 p.m. will be accommodated as rooms become available. Checkout time is 11:00 a.m. Arrangements can be made for baggage storage beyond 11:00 a.m.

Visit the Exhibits

Exhibits are an integral part of the Med Chi Semiannual Meeting and are a valuable adjunct to the scientific program. During this year's semiannual meeting, Med Chi has allocated several special time periods for physicians to meet one-on-one with exhibitors. By visiting exhibits, you will help ensure that Med Chi continues to receive valuable income that allows us to offer these annual and semiannual meetings.

Med Chi urges you to express your appreciation to exhibitors by visiting their booths and discussing your mutual involvement in patient care.



Please note: Exhibit Hours

Friday - 12:00 p.m. - 7:00 p.m.
Saturday - 8:00 a.m. - 3:00 p.m.
Sunday - NO EXHIBITS

Directions to the Princess

The Princess Royale Hotel is located at 9100 Coastal Highway, Ocean City, Maryland (Oceanfront at 91st Street).

From Baltimore: From Baltimore, take the 695 Beltway to Route 97 South (follow the signs directing traffic toward the Bay Bridge/Annapolis area). Follow 97 South until it ends on Route 50 East in Annapolis. Follow Route 50 East over the Chesapeake Bay Bridge (Toll east bound $2.50. No toll west bound). Stay on Route 50 East through Easton, Cambridge, and Salisbury. As you approach Ocean City, take the Route 90 East exit. As Route 90 East ends, you will cross over two bridges and you will see Ocean City in the distance. Route 90 East ends at Coastal Highway in Ocean City, Maryland. At the Route 90 and Coastal Highway intersection, get in the left turn lane. Turn left onto Coastal Highway and follow the street signs to 91st Street. The Princess Royale Hotel will be on your immediate right at 91st Street. Valet parking is available or you may park yourself in the private parking garage. Parking is complimentary.

From Washington, D.C. area: Take the 495 Beltway toward College Park/Silver Spring and follow to Route 50 East. Follow the directions above from Route 50 East.

From all points south of Ocean City: Take I-95 North to Route 58 East in Emporia, VA. From Route 58 East, follow signs for Chesapeake Bay Bridge Tunnel and Route 64 East. Take Route 64 East to Route 13 North and Bay Bridge Tunnel (this is a toll bridge approximately $10.00 each way). Follow Route 13 North to Pocomoke City, Maryland and Route 113 North. Take Route 113 North to Route 90 East into Ocean City, Maryland. Route 90 East ends at Coastal Highway in Ocean City. At the Route 90/Coastal Highway intersection, get into the left turn lane. Turn left onto Coastal Highway and continue north following the street signs to 91st Street. The Princess Royale Hotel will be on your immediate right at 91st Street. Valet parking is available or you may park yourself in the private parking garage. Parking is complimentary.

From Philadelphia: Follow I-95 South towards Wilmington, Delaware. Take 495 South around Wilmington. Follow the signs toward Dover — Route 13 South. As approaching Dover, follow signs toward NEW Route 1. This bypass around Dover continues along the Delaware shore and eventually becomes Coastal Highway in Ocean City, Maryland. Once in Ocean City continue down Coastal Highway towards 91st Street. The Princess Royale Hotel is located at 91st Street and the Ocean. You will need to go past 91st Street to Pacific Avenue and make a U turn at the traffic light. The Princess will be one block ahead on your right. Valet parking is available or you may park yourself in the private parking garage. Parking is complimentary.





Keynote Speaker

Richard E. Corlin, M.D.
Speaker of the House of Delegates, American Medical Association

Richard E. Corlin, M.D., was elected speaker of the AMA House of Delegates in June 1995, having served as vice-speaker of that body from 1991-1994.

For nine years he served as the California Medical Association's (CMA) speaker and vice-speaker and as president of CMA in 1992-1993. In addition, he was a member of the CMA Board of Trustees for 11 years, and a member of the CMA House of Delegates for 18 years. He has been a member of the AMA House of Delegates for over a decade.

Dr. Corlin was instrumental in helping diversify representation in the AMA House of Delegates as head of a committee that brought young physicians into the AMA House. He was also in charge of the panel that ultimately created the AMA Hospital Medical Staff Section (HMSS).

He is a member of the American Gastroenterology Association, the American Society of Gastrointestinal Endoscopy, past president of the Southern California Society for Gastrointestinal Endoscopy, and a member of the Board of Directors of the American Digestive Disease Society.

Dr. Corlin is a gastroenterologist in Los Angeles. He received his medical degree from Hahnemann Medical College in Philadelphia. He is board certified and a fellow of the American College of Physicians. He also is an assistant professor at UCLA School of Medicine.

Friday, September 8, 1995

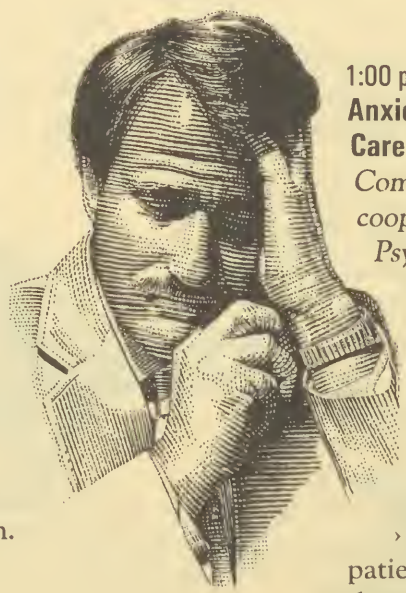
11:30 a.m. - 5:00 p.m.
Registration Open

12:00 p.m. - 7:00 p.m.
Exhibits Open

11:30 a.m. - 12:45 p.m.
Maryland Medical Political Action Committee Board of Directors Meeting

12:30 p.m. - 1:00 p.m.
House of Delegates Registration
All delegates and alternates must register during this time and be seated by 1:00 p.m. when the meeting begins.

1:00 p.m. - 4:00 p.m.
House of Delegates Meeting



1:00 p.m. - 2:00 p.m.
Anxiety and Depression in the Primary Care Office
Committee on Scientific Activity in cooperation with the Maryland Psychiatric Society
Speaker:
Arthur M. Hildreth, M.D., F.A.P.A., Co-Chair, Department of Psychiatry, Union Memorial Hospital
Objectives: Participating physicians will be
› better prepared to identify patients suffering from depression and anxiety,
› able to describe steps that can be taken by physicians of any specialty to help some of these patients, and
› able to identify patients who should be referred to a specialist.
Target Audience: All physicians
CME Credits: 1

1:00 p.m. - 2:00 p.m.

Hepatitis in Children: Cooperative Interventions

Committee on Scientific Activity

Speakers: Oscar Taube, M.D., Department of Pediatrics, Sinai Hospital

David Tuchman, M.D., Department of Gastroenterology, Sinai Hospital

Objectives:

After attending this program, the participant will be able to

› identify immunization strategies for the prevention of hepatitis A, B, C, D in infants, children, and adolescents,

› describe the signs, symptoms, and serologic markers, and know the differential diagnosis for hepatitis A-D,

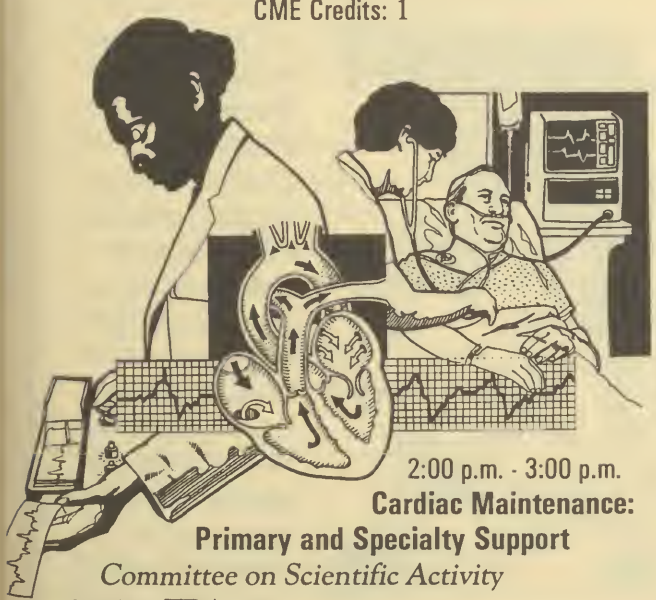
› educate and advise the child and family with uncomplicated hepatitis infection,

› describe acute and chronic complications of hepatitis A-D, and identify therapies for chronic hepatitis infection, and

› know when to refer the infant, child, or adolescent hepatitis patient to the specialist.

Target Audience: Pediatricians, primary care physicians and gastroenterologists

CME Credits: 1



2:00 p.m. - 3:00 p.m.

Cardiac Maintenance: Primary and Specialty Support

Committee on Scientific Activity

Speaker: TBA

Objectives: Participating physicians will

› become aware of common cardiac problems and their physiological effects, and

› be able to describe the roles of the primary care and specialty physician in the treatment and maintenance of the cardiac patient.

Target audience: All physicians

CME credits: 1

2:00 p.m. - 3:00 p.m.

Epilepsy in Children: Pediatricians and Neurologists in Collaboration

Committee on Scientific Activity

Speaker: Thomas Koch, M.D., Director, Pediatric Neurology, University of Maryland School of Medicine

Objectives:

Participating physicians will be

› aware of the neurologic problems most frequently encountered by the primary care pediatrician,

› able to describe the difference between paroxysmal non-epileptiform disorders (PNED) and true epilepsy,

› able to describe the classification system used to categorize the types of epileptic seizures,

› able to describe the indications and contraindications for the most common antiepileptic drugs, and

› able to identify patients who should be referred to a specialist.

Target Audience: Pediatricians, family practitioners, internists

CME Credits: 1

3:00 p.m. - 4:00 p.m.

Physician Legal Responsibilities in Completing Death Certificates

Committee on Public Health

Speaker: Julia Davidson-Randall, M.S.

Objectives: Participating physicians will be able to

› complete a death certificate in accordance with the legal mandate (accurately, completely, and in a timely fashion),

› describe the benefits of accurate, complete and timely reports to the family of the deceased as well as the state and

› be familiar with initiatives to enhance coordination between providers of data including meetings between Med Chi physicians and funeral directors, and completion of death certificates by electronic transfer.

Target audience: All physicians

CME credits: 1

4:00 p.m. - 4:30 p.m.

Break - Visit the Exhibits

4:30 p.m. - 5:30 p.m.
Physician Legal Responsibilities in Completing Death Certificates
Committee on Public Health
Repeat of 3:00 p.m. session — CME credit cannot be earned for attendance at both sessions.

4:30 p.m. - 6:00 p.m.
Child Abuse: Every Physician's Concern
Speaker: TBA
Objectives:
Participating physicians will be able to
› define child maltreatment and its characteristics,
› recognize types of abuse and barriers to identification,
› recognize clinical findings related to child maltreatment, and
› become aware of the physician's role in the legal process.
Target audience: All physicians
CME credits: 1.5

6:00 p.m. - 7:00 p.m.
Welcome Reception —Exhibits Open
All physicians, spouses, and exhibitors welcome. Compliments of the Med Chi Insurance Agency, Inc.

Saturday, September 9, 1995

7:30 a.m. - 5:00 p.m.
Registration Open

7:30 a.m. - 9:00 a.m.
Innovative Financial Strategies
Attend an overview of this educational seminar and learn the basic principles of effective estate, retirement, and insurance planning! Learn how to achieve your financial goals and protect your income and assets from taxes and inflation. This program is presented by the Med Chi Insurance Agency and AMA Investment Advisors, L.P.
Target audience: Physicians and spouses, age 40 and over
CME credits: None
Seating for this breakfast meeting is limited to 50 people. Tickets will be available from the Med Chi Agency booth in the exhibit hall.

8:00 a.m. - 3:00 p.m.
Exhibits Open



8:00 a.m. - 9:00 a.m.
Recognition and Management of Glaucoma
Committee on Scientific Activity
Speaker: Irvin P. Pollack, M.D., Ophthalmologist Chief and Director, Krieger Eye Institute, Sinai Hospital
Objectives:
Participating physicians will be able to
› describe the status and goals of the Glaucoma 2001 initiative, and
› recognize and appropriately refer for treatment patients at high risk for glaucoma
Target audience: Primary care physicians
CME credits: 1

9:00 a.m. - 12:00 p.m.
Reference Committees

9:00 a.m. - 10:00 a.m.
Collaboration in the Treatment of Prostatic Cancer
Committee on Scientific Activity
Speaker: Dr. Stephen Jacobs, Chief of Urology, University of Maryland School of Medicine
Objectives:
Participating physicians will be able to describe
› the role of the primary care physician in the screening process for prostate cancer,
› options for treatment available for control of prostate cancer,
› the role of the primary care physician in the management of advanced prostate cancer, and
› coordination of treatment between the primary care and specialty care physician.
Target audience: Primary care physicians
CME credits: 1

9:00 a.m. - 10:00 a.m.
How to Help your Patients Stop Smoking
Committee on Scientific Activity in cooperation with the Smoke Free Maryland Coalition
Speaker: Joseph A. Adams, M.D., Secretary, Smoke Free Maryland Coalition
Objectives:
Participating physicians will be able to
› describe the magnitude of the health risks posed by tobacco addiction,
› use current, effective smoking cessation counseling techniques **in a minimal contact setting,**
› understand indicators and appropriate use of pharmacological treatment for nicotine addiction
Target audience: All physicians
CME credits: 1

10:00 a.m. - 11:00 a.m.
Break — Visit the Exhibits

10:00 a.m. - 2:30 p.m.
Med Chi Alliance Business Meeting, Speaker and Luncheon



11:00 a.m. - 12:00 noon
New Cardiac Interventions for MI: What Every Doctor Needs to Know
Committee on Scientific Activity
Speaker: Donald H. Dembo, M.D., Immediate Past President
Objectives:
Participating physicians will be able to describe
› key manifestations of incipient MIs and
› new treatments for MI.
Target audience: Primary care physicians
CME credits: 1

11:00 a.m. - 12:00 noon
Collaborative Practices — Problems in Forming and Maintaining
Committee on Scientific Activity
Speaker: F. Graham Fallon, M.D.
Objectives:
Participating physicians will be
› aware of the difficulties in forming a multi-specialty group practice and
› able to describe strategies to resolve problems during the formation of and after the establishment of the new practice.
Target audience: All physicians
CME Credits: 1

12:00 noon - 1:00 p.m.
Lunch break

1:00 p.m. - 2:00 p.m.

Keynote Address—Primary and Specialty Care in the 21st Century

Committee on Scientific Activity

Speaker: Richard E. Corlin, M.D., Speaker of the House of Delegates, American Medical Association

Objectives:

Participating physicians will be able to

› describe the importance of primary care base when organizing delivery systems,
› discuss how to deal with physician surplus especially with regard to specialists, and
› describe the importance of group thinking.

Target audience: All physicians

CME credits: 1

2:00 p.m. - 3:00 p.m.

Break — Visit the Exhibits

3:00 p.m. - 4:30 p.m.

Plenary Session — Working Together: Primary Care and Specialty Care Physicians in Today's Health Care Climate

Committee on Scientific Activity

Moderator: Alex Azar, M.D., President Elect, Medical and Chirurgical Faculty of Maryland

Panel:

Niharika Khanna, M.D., Assistant Professor of Family Medicine, University of Maryland School of Medicine

J. Leonard Lichtenfeld, M.D., Secretary/Treasurer of the American Society of Internal Medicine

Paul McClelland, M.D., Chairman, Department of Psychiatry, GBMC and President of Maryland Psychiatric Society

Gary I. Cohen, M.D., Director, Cancer Center, GBMC

J. Courtland Robinson, M.D., Johns Hopkins School of Medicine

Objectives: The panel will

› discuss the changing roles and relationships between primary care and specialty care physicians in today's health care climate,
› discuss impacts on patients and outcomes of care, and
› offer guidance and solutions.

Target Audience: All physicians, other health care providers, and consumers

CME Credits: 1.5



4:30 p.m. - 6:30 p.m.

Screening for Breast Cancer

Women in Medicine Committee

Speaker: Catherine A. Kiley, M.D., Master Faculty Member, The Breast and Cervical Cancer Education Project, American Medical Women's Association and Center for Disease Control and Prevention

Objectives:

Participating physicians will be able to

› identify strategies for encouraging breast cancer screening in general practice settings,
› describe the various techniques used to screen for breast cancer,
› describe the risk factors for breast cancer,
› identify follow-up strategies for breast abnormalities and
› describe breast examination techniques.

Target audience: All physicians

CME credits: 2

4:30 p.m. - 6:30 p.m.
Suit Survival/Lessons in Risk Management
Committee on Scientific Activity in cooperation with the Medical Mutual Liability Insurance Society of Maryland
Moderator: Daniel Kohn, M.D., Staff Physician, Emergency Department, Harbor Hospital Center
Speakers: Daniel Kohn, M.D.
Wayne Zack
Dale Adkins, Esq.
Objectives: Participating physicians will
› be able to identify current patient care issues as they relate to risk management concerns,
› understand risk management principles through examination of case studies of medical diagnostic and treatment options,
› understand the litigation process and how to deal with aspects of a lawsuit, and
› be able to discuss the application of risk management recommendations.
(Medical Mutual members who attend this session are eligible for a 5% discount on their 1996 medical liability renewal policy. A $40 program fee is required for this discount.)
Target Audience: All physicians
CME Credits: 2

6:30 p.m. - 7:30 p.m.
Reception for Women in Medicine, Young Physicians, Students and Residents
Women physicians, young physicians, residents and medical students and their guests welcome to this complimentary reception. Network with your colleagues and meet members of the Med Chi Board of Trustees.

8:00 p.m.
Crab Feast
Phillips Crab House
2004 Philadelphia Ave
Ocean City, MD 21842
Have dinner with your colleagues and enjoy Phillips' Seafood Festival Buffet. Buffet items include all you can eat steamed crabs, mussels, clams and shrimp, crab soup, crab cakes, carved roast beef and ham, rotisserie chicken, fresh salads, pasta, desserts, iced tea and coffee. **Preregistration and fee required (see registration form) Reserve now–space is limited!**

Sunday, September 10, 1995

8:00 a.m. - 12:00 p.m.
Registration Open

8:30 a.m. - 9:00 a.m.
House of Delegates Registration
All delegates and alternate delegates must register during this time and be seated by 9:00 a.m. when the meeting begins.

9:00 a.m. - 12:00 p.m.
House of Delegates Meeting

8:00 a.m. - 9:00 a.m.
Nothing to Sneeze At: Latex and Other Environmental Allergies
Committee on Scientific Activity
Speaker: Clifford S. Mitchell, M.D., M.S., M.P.H., Instructor, the Johns Hopkins University School of Hygiene and Public Health
Objectives:
Participating physicians will be able to
› describe the initial evaluation and testing of a patient presenting with a suspected environmental allergy,
› describe the management of the patient, and
› describe treatment for contact latex allergy among health care workers.
Target audience: All physicians
CME credits: 1





8:00 a.m. - 9:00 a.m.

Minor Surgical Techniques for Primary Care Physicians

Committee on Scientific Activity

Speaker: David P. Zajano, M.D., Co-Director of Family Practice Residency Program, Franklin Square Hospital

Objectives:

Participating physicians will be able to identify

› minor surgical procedures which can be performed immediately, efficiently and effectively, such as repair of simple lacerations, breast cysts and toenail removal

› complicating factors that would necessitate referral, and

› liability issues.

Target audience: Primary care physicians

CME credits: 1

9:00 a.m. - 10:00 a.m.

When Snoring Is No Laughing Matter

Committee on Scientific Activity

Speaker: Karl W. Diehn, M.D., Private practice, specializing in otolaryngology

Objectives:

Participating physicians will be able to

› identify patients who would be appropriate to refer for treatment by a specialist and

› describe interventions to alleviate snoring.

Target audience: All physicians

CME credits: 1

9:00 a.m. - 10:00 a.m.

Keeping the Primary Care Physician Involved: Opioid Addiction

Committee on Scientific Activity

Speaker: N. Joseph Gagliardi, M.D., Family Physician and Addictionologist

Objectives:

Participating physicians will

› understand the primary care physician's role in diagnosing and treating opioid addicted patients; recognize signs and symptoms of opioid addiction; identify clinical procedures for diagnosing opioid addiction,

› understand when and how to refer opioid addicted patients for detoxification and/or treatment; describe various treatment options for opioid addicted patients, and

› identify strategies for maintaining relationship with patient and treatment provider while patient is in treatment.

Target Audience: Primary care physicians

CME Credits: 1

10:00 a.m. - 11:00 a.m.

Wound Care Dynamics and Evolving Strategies

Committee on Scientific Activity

Speakers: Alexander M. Guba, Jr., M.D., President, John Staige Davis Plastic Surgeons Society of Maryland

Susan Currence, R.N., B.S.N, C.E.T.N., Ostomy and Wound Care Specialist, St. Joseph's Medical Center

Objectives:

Participating physicians will be able to

› describe three types of wounds,

› discuss the phases of wound healing,

› list two intrinsic factors that influence wound healing,

› identify six different categories of wound care dressings and

› list three methods of adjunctive therapy.

Target audience: All physicians

CME Credits: 1

10:00 a.m. - 11:00 a.m.

The Ailment That Crosses All Specialties - Lower Back Pain

Committee on Scientific Activity

Speaker: Kenneth Silver, M.D., Director of Outpatient Services, Montebello Hospital, Attending Physiatrist

Objectives:

Participating physicians will

› review the anatomy/ physiology of the lower back,

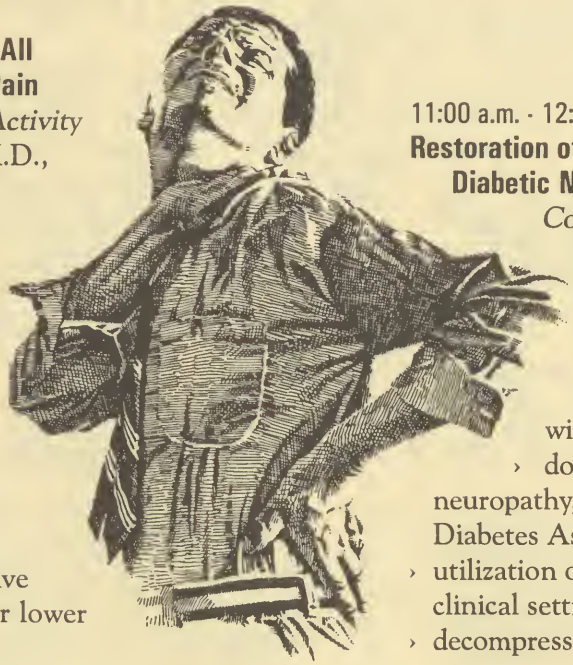
› be able to discuss indicators for conservative vs. surgical treatment for lower back pain,

› be able to describe a variety of nonsurgical treatments for lower back pain and

› be able to describe the new federal guidelines for the treatment of lower back pain.

Target Audience: All physicians

CME Credits: 1



11:00 a.m. - 12:00 noon

Internet Medical Information Resources

Library and History and Computers in Medicine Committees

Moderator: Dino Flores, M.D., Chair, Computers in Medicine Committee

Speakers: Joseph Berkow, M.D. Assistant Professor of Ophthalmology Johns Hopkins School of Medicine

Stephen M. Jones, Manager, Information Services, Med Chi Library

Objectives:

Participating physicians will understand

› the wide range of medical resources available on the Internet,

› the hardware and software required to access the Internet, and

› the impact that the World Wide Web's graphical capabilities are having on medicine.

Target audience: All physicians

CME credits: 1

11:00 a.m. - 12:00 noon

Restoration of Sensation Lost as a Result of Diabetic Neuropathy

Committee on Scientific Activity

Speaker: A. Lee Dellon, M.D., F.A.C.S., Professor of Neurosurgery, The Johns Hopkins School of Medicine

Objectives: Participating physicians will be able to discuss

› documentation of peripheral neuropathy, as recommended by the American Diabetes Association and third party payers,

› utilization of quantitative sensory testing in clinical settings, and

› decompression of peripheral nerves to treat symptoms.

Target Audience: Primary care physicians

CME Credits: 1

12:00 p.m.

Adjournment



Registration Form

1995 Semiannual Meeting of the
Medical and Chirurgical Faculty of Maryland
Friday - Sunday, September 8-10, 1995
Princess Royale Oceanfront Hotel and Conference Center, Ocean City

Check one:

- ❑ Med Chi member - no charge
- ❑ Preregistered nonmember - $200 (includes all CME presentations)

Babysitting Services

- ❑ Please check here if you are interested in babysitting services and a form will be mailed to you.

Event Preregistration

- ❑ **Crab Feast – Saturday, September 9, 8:00 p.m.**
  Adults: _____at $25.00/person
  Children (6-10 years)_____ at $9.00/ea.
  (Children 5 years and under eat free.)

Total:_____

Name_____

Address_____

City, State_____ **Zip**_____

Phone_____

Component Society (County/City)

_____

Spouse name (only if attending the semiannual meeting)

_____

Please return this form (and check made payable to "Med Chi" if applicable) to:

Med Chi Communications Department
1211 Cathedral Street
Baltimore, MD 21201

For additional information, call Heather Johnson, Vivian Smith, or Ruth Seaby at 410-539-0872 from the Baltimore area or 1-800-492-1056 from elsewhere in Maryland.

Special Events

Friday, September 8, 1995

6:00 p.m. - 7:00 p.m.

Welcome Reception

Visit with your colleagues and exhibitors and enjoy drinks and hors d'oeuvres compliments of the Med Chi Insurance Agency and the Princess Royale Hotel. Exhibits will be open during this event.

Saturday, September 9, 1995

7:30 a.m. - 9:00 a.m.

Innovative Financial Strategies

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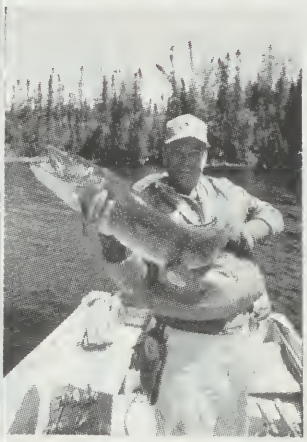
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Wondering

The Hippocratic oath in brief: I swear . . . so far as power and discernment shall be mine . . . for the benefit of my patient . . . I will abstain from whatever is deleterious and harmful . . . .

Sixty-one years ago (before IQ tests and SAT scores), I, one of 78 students accepted, began the study of medicine under the care and instruction of dedicated teachers. Four years later, those dedicated teachers saw fit to allow me and 42 classmates the privilege to take the Oath of Hippocrates, to become a member of that honored profession: a physician, a healer, a servant to my fellow man.

After a one-year rotating internship (room, board, laundry and $15 a month out of which I bought my uniforms); 56 years in private general practice; 2000 home and hospital deliveries; 500 000 and more office, home, and hospital patient visits (during which time 12- to 20-hour days were routine—except for a four-and-a-half-year vacation in the Army Medical Corps and a one-year sabbatical working in a Veterans Administration hospital as a psychiatrist, when it was crack up or get out), I am still seeing patients, learning, and wondering. I am wondering what is happening to that honorable profession of medicine (*for the benefit of my patient*), what is its destination?

I am wondering why 50 and more years ago, comparatively simple medicines did so much good—medicines that today have been discontinued or are seldom used. Did our patients then have more faith in us? Or were they not so sophisticated, educated, and/or demanding? Or are our medicines today so much better? There is no question that there has been a change in the patient, the physician, the medicines, and the methods used. All to the better? I tend to be a little skeptical, but try to keep an open mind.

I am wondering why there seems to be more anxiety, discomfort, and litigation involving physicians. I am wondering why, with all the tremendous improvement in medical care in the past half-century, the government wants to regulate professionals with nonprofessional politicals. Is it because we the physicians have lost our sense of autonomy? Has our public lost its sense of freedom, its self-respect? Do we really know the importance of autonomy? Of freedom? Do we know its responsibilities? Have we physicians in general lost the sense of our mission?

Fortunate to have been born early in this century; fortunate to be a first-generation American and to have learned the value of freedom. Fortunate to have lived during the Depression of the 1930s. Fortunate to learn how to drive a two-horse-power (one was called Jim; the other, Dan) tractor. Fortunate to have learned, on my first day of summer vacation, the pain of

Speak Out

13 blisters on my hands from the handle of the pole ax handed me that morning. Fortunate to have had a mother with six weeks of formal education who taught me some common sense. Fortunate to have had a father who, when I was all of perhaps that lazy, lanky age of 17, brought me up straight with, "Tighten your ass and lift." Fortunate to have had a hard-working, caring, sacrificing family who saw me through school.

Fortunate to graduate in the era of the sulfonamide precursors; pneumonia and other vaccines; the surge in prenatal, natal, and postnatal care; early infant feeding, and vitamins. In the era of very modest fees, when patients were seen without being asked if they had insurance or the money to pay. In an era when you knew what that patient probably had for breakfast, who his family and neighbors were, what church he attended, where he worked, and what he probably earned. In an era when people had a tendency to blame irresponsibility on themselves and we physicians understood our mission.

And years later, that mother who was proud of her doctor son came to the office to see him because he was too busy to stop to see her. She discovered that the waiting room door was locked at 9:00 p.m. the previous evening because people would stop by, find the waiting room full, go to the movies, then come back when there were vacant chairs. She called him aside and said, "You! Don't you remember how hard we all worked so you could learn to be a doctor so you could help people? And now, you are going to lock the door so people who need and want you can't come to see you?" She understood poverty; and the poverty of all poverty was illness, when a man was sick and couldn't work to earn his living. The waiting room door was never locked again until the last patient was seen, no matter what time of the night or morning.

Reflecting on the past trials and progress—and not in criticism—I wonder: How many of my fellow physicians take the Oath of Hippocrates in deep seriousness and visualize their real responsibility in caring for their fellow men? In these turbulent times, with a long-distance vision to the future welfare of my fellow man and my country, I ask questions and wonder.

I will abstain from whatever is deleterious and harmful . . . to person . . . ? to my country . . . ? our character . . .?

While I keep this oath . . . be it granted to me . . . to enjoy life and the Practice of the Art . . . respected by all men . . . should I violate and trespass . . . may the reverse be my lot.

ANDREW E. MANCE, M.D.
Oakland, Maryland ■

LETTERS TO THE EDITOR

Managing sinusitis

I am a retired family physician. The following comments pertain to Dr. Biedlingmaier's article on the management of chronic sinusitis (*Md Med J* 1995;44:289-291). While I agree that chronic sinusitis should be treated, I take issue with the bulk of Dr. Biedlingmaier's dicta. I do not agree with his recommendation for antibiotic therapy. Blood supply to the nasal sinus cavities is conspicuous by its absence, which fact makes antibiotic therapy largely an exercise in futility. Furthermore, such misuse of antibiotics adds to an already alarming increase in resistance to commonly employed agents. In general, the long-term effects of the decongestants and steroids Dr. Biedlingmaier recommends as adjunctive therapy are negligible to negative.

Only obstructed sinuses become infected. It follows that one need only restore natural drainage to effect this restoration.

Although it is indeed possible to effect this restoration by a variety of surgical procedures, a surgical approach is unnecessary and uncalled for in the bulk of sinus infections. The only "medication" and "equipment" required are a supply of table salt, access to lukewarm tap water, and an eight-ounce tumbler. The patient is shown how to "snuff" a weak saline solution through the nose and to direct the fluid into each of the sinuses twice daily. Time required: approximately two minutes. Cost: negligible. Result: well-draining sinuses and absence of infection in a month to six weeks of self-administered therapy.

The same result can be obtained from a two- to three-month vacation at Waikiki with daily surfboarding. Although the latter election would obviously represent a more pleasant approach and probably would cost no more than Dr. Biedlingmaier's surgery, it is an unnecessary expense: twice daily salt water snuffing will accomplish the same purpose.

PAUL G. H. WOLBER, M.D.
Hagerstown, Maryland

Dr. Biedlingmaier replies

I appreciate Dr. Wolber's comments. I will certainly take issue with his comment about the absence of nasal blood supply. Anyone who has ever treated a patient with a nosebleed would realize that the nose and sinus cavities have a significant blood supply. I would also like to caution all of the readers of this letter against rinsing the nose with tap water. Even though public water is chlorinated, the plumbing can and does get colonized by coliform bacteria such as *E. coli* and Pseudomonas. Contamination can be even more significant if the patient's water supply comes from a well. Using a tap water solution as described by Dr. Wolber will result in colonization of the nasal tissue with bacteria that are extremely difficult to eradicate.

JOHN F. BIEDLINGMAIER, M.D., F.A.C.S.
Baltimore, Maryland



The Trimble family

I certainly enjoyed reading Dr. Joseph Miller's article, "Vignette of Medical History: The Trimbles of Baltimore" (*Md MedJ* 1995;44:47-49). It seems a shame not to add a small coda to the article, however, since there are so many other physicians still active in Baltimore and elsewhere who also are members of this distinguished Maryland family.

Dr. I. Ridgeway Trimble's wife, Frances H. Trimble, is a distinguished adjunct member of the clan. Educated in Australia, she came to Baltimore as Dr. Trimble's bride and had an enormous impact on the community professionally, due in part to her position for many years as director of Planned Parenthood. Two sons of the Drs. Trimble, I. Ridgeway Trimble, Jr., and Edward Lloyd Trimble, have both followed the family path into medicine, although each has added his own variations to the theme. Ridge Trimble is now practicing emergency medicine in southern California. Ted, after graduating from Harvard College and the Hopkins schools of medicine and public health and training at Vanderbilt in obstetrics and gynecology with a fellowship in gynecologic oncology, is now practicing at Hopkins. His wife, Dr. Cornelian Liu Trimble, educated at Princeton and Vanderbilt medical school, is a board-certified pathologist who is now completing an additional obstetrical and gynecological residency at Hopkins.

Thus, Maryland medicine continues to be served by the outstanding contributions of the Trimble family.

JULIA A. HALLER, M.D.
Baltimore, Maryland

I am grateful to Dr. Haller for her kind comment about the Trimble history. My primary interest was in Ridge, whom I knew as a surgeon and a friend. I was aware of the present medical members of the family, but purposely did not mention them as my primary interest lay elsewhere. Med Chi is fortunate in that it can cherish the memories of many medical families, of whom the Trimbles are one.

JOSEPH M. MILLER, M.D.

Erratum

On page 548 in the July 1995 issue, Senator Dorman's name was misspelled. *Maryland Medical Journal* regrets the error.

Letters To The Editor

The editorial board of the *Maryland Medical Journal* welcomes comments, criticisms, recommendations, and observations from all its readers. Please submit letters to

Editor
Maryland Medical Journal
1211 Cathedral Street
Baltimore, MD 21201-5585

Joseph M. Miller, M.D., a retired surgeon in Timonium, Maryland, is the coauthor of a guest editorial published in the *Journal of the National Medical Association* (1995;87:261-262) on studies involving Duffy antigens and genetic changes that have occurred in white and black people.

Sheila Sheth, M.D., an assistant professor of radiology at The Johns Hopkins University School of Medicine, is the lead author of a study indicating that color duplex Doppler endovaginal ultrasonography may not be a useful diagnostic tool in women with suspected endometrial cancer (*Radiology* 1995;195:661-665).

Howard Dubowitz, M.D., an associate professor of pediatrics at University of Maryland Medical Center, is among the authors of a report on a randomized clinical trial of home intervention for children with failure to thrive. Results indicate that visits by trained lay professionals may be useful in promoting infant development (*Pediatrics* 1995;95:807-814).

Jonathan P. Weiner, Dr.P.H., an associate professor of health policy and management at The Johns Hopkins University School of Hygiene and Public Health, is the lead author of a three-state study indicating that elderly patients with diabetes treated in ambulatory settings may receive suboptimal care (*JAMA* 1995;273:1503-1508).

Daniel F. Hanley, M.D., and **John A. Ulatowski, M.D., Ph.D.,** are the authors of an editorial on the medical management of aneurysmal subarachnoid hemorrhage (*Crit Care Med* 1995;23:992-993). Dr. Hanley is an associate professor of neurology and Dr. Ulatowski is an assistant professor of anesthesiology and critical care medicine at The Johns Hopkins University School of Medicine.

John P. Gearhart, M.D., director of the division of pediatric neurology at The Johns Hopkins University School of Medicine, is the lead author of a study to define ultrasonographic criteria for the prenatal diagnosis of classic bladder exstrophy (*Obstet Gynecol* 1995;85:961-964). Other Hopkins physicians involved in the study are Jacob Ben-Chaim, M.D., Robert D. Jeffs, M.D., and Roger C. Sanders, M.D.

Andrew R. Burgess, M.D., chief of orthopedic traumatology at the R Adams Cowley Shock Trauma Center and director of the Center for Occupant and Pedestrian Studies, in Baltimore, is the lead author of a study of lower extremity injuries in drivers of airbag-equipped automobiles (*J Trauma* 1995;38:509-516).

Robert A. Vogel, M.D., director of cardiology at University of Maryland Medical Center, is among the authors of a four-state study designed to assess the quality of care received by Medicare patients with acute myocardial infarction (*JAMA* 1995;273:1509-1514).

Michael Miller, M.D., director of preventive cardiology at University of Maryland Medical Center, is the lead author of a report (*J Lipid Res* 1995;1995:931-938) describing what is believed to be the youngest patient yet identified with lecithin cholesterol acyl-transferase deficiency. Among Dr. Miller's co-authors is **Peter Kwiterovich, M.D.,** professor of pediatrics and medicine at The Johns Hopkins University School of Medicine.

Frank R. Witter, M.D., an assistant professor of obstetrics and gynecology at The Johns Hopkins University School of Medicine, is the lead author of a study indicating that the risk of cesarean delivery increases linearly with pregnancy weight gain, independent of birth weight (*Obstet Gynecol* 1995;85:047-951).

Robert E. Black, M.D., M.P.H., professor and chairman of the department of international health at The Johns Hopkins School of Hygiene and Public Health, and **James B. Kaper, Ph.D.,** professor of medicine, microbiology, and immunology at the University of Maryland Medical Center, were members of a nonadvocate panel of experts that prepared a consensus conference statement on the emerging national health crisis associated with *Escherichia coli* 0157:H7 infections (*Gastroenterology* 1995;108:1934).

Oliver O. Schein, M.D., M.P.H., an assistant professor of ophthalmology at The Johns Hopkins University School of Medicine, is the lead author of a study indicating that four preoperative characteristics (age, ocular comorbidity, cataract symptom score, and degree of functional impairment) may be independent predictors of outcome in patients undergoing cataract surgery (*Ophthalmology* 1995;102:817-823).

Ernest Moy, M.D., M.P.H., and **Barbara A. Bartman, M.D., M.P.H.,** are the authors of a study published in the *Journal of the American Medical Association* (1995;273:1515-1520) indicating that nonwhite physicians are more likely to care for minority, medically indigent, and sicker patients. Drs. Moy and Bartman are assistant professors of medicine at University of Maryland Medical Center.

Thomas E. Finucane, M.D., director of the elder house call program at the Johns Hopkins Bayview Medical Center and an associate professor of geriatric medicine at The Johns Hopkins School of Medicine, is the author of a study indicating that existing data do not clearly support routine use of tube feeding to prevent or treat pressure sores (*J Am Geriatr Soc* 1995;43:447-451).

Mukund S. Didolkar, M.D., director of surgical oncology, and **Selwyn M. Vickers, M.D.,** formerly chief resident at Sinai Hospital of Baltimore, are the authors of a report describing perixiphoid extension of the midline upper abdominal incision to allow access to the esophageal hiatus, esophagogastric junction, and hepatic veins (*J Am Coll Surg* 1995;180:739-741).

Thomas J. Polascik, M.D., and **Patrick C. Walsh, M.D.,** report finding an accessory pudendal artery in 4% of men undergoing radical retropubic prostatectomy, preservation of which may not increase potency rates, but dissection of which may be associated with excessive bleeding (*J Urol* 1995;154:150-152). Dr. Polascik is a fellow in urology and Dr. Walsh is director of the department of urology at The Johns Hopkins University School of Medicine.

Richard Y. Hinton, M.D., a fourth-year resident in the department of orthopedic surgery at The Union Memorial Hospital in Baltimore, is the lead author of a study designed to determine geographic, sex-specific, and age-interval variations in the relative risk of hip fracture among elderly white individuals (*J Bone Joint Surg Am* 1995;77-A:695-702).

Florence Houn, M.D., M.P.H., Kathy J. Helzlsouer, M.D., M.P.H., Neil B. Friedman, M.D., and **Michael E. Stefanek, Ph.D.,** are the authors of a report on the practice of prophylactic mastectomy among surgeons licensed to practice in Maryland (*Am J Public Health* 1995;85:801-805). Drs. Houn, Helslsouer, and Stefanek are associated with the oncology center, and Dr. Friedman is assocated with the department of surgery at The Johns Hopkins Hospital.

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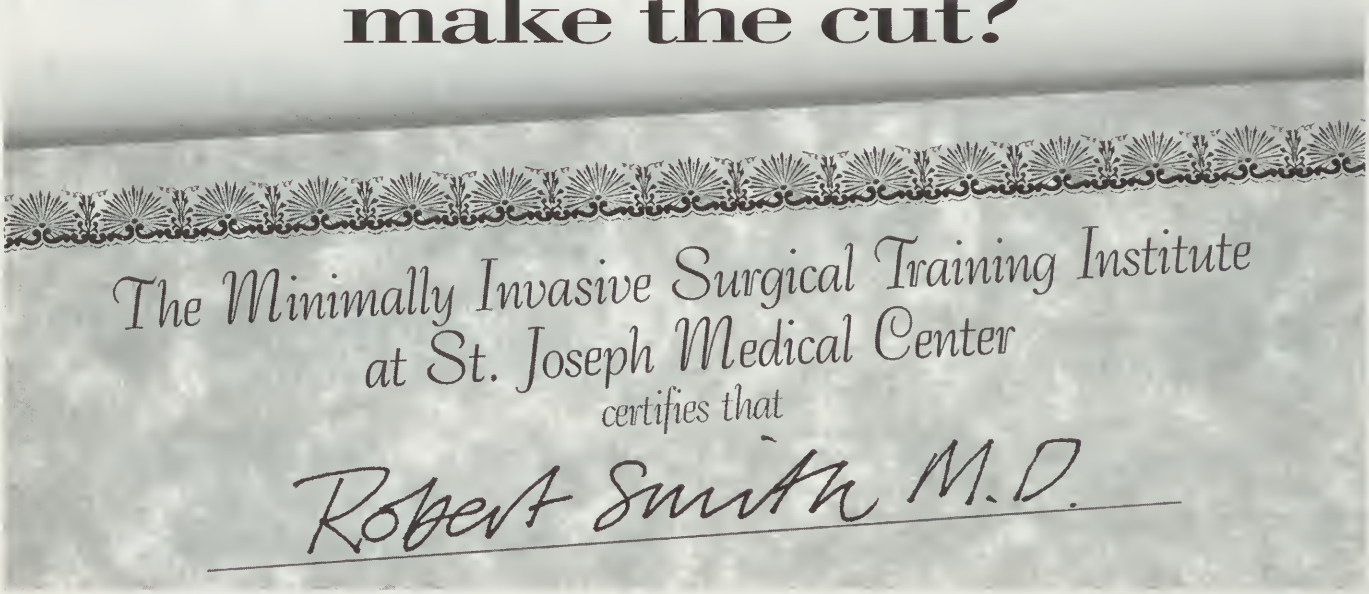
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- "Reflex Sympathetic Dystrophy"
  Ability, Vol. 95 Issue VI
- "Parenting. Understanding ADHD"
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  U.S. News & World Report, June 26, 1995
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Theodore E. Woodward, M.D., recipient of the 1995 American Medical Association Distinguished Service Award



Robert E. McAfee, M.D., 1994-1995 president of the AMA, presents Dr. Woodward with the 1995 American Medical Association Distinguished Service Award on June 18, 1995.

Theodore E. Woodward, M.D., professor of medicine emeritus at the University of Maryland School of Medicine and Hospital and emeritus member of Med Chi, was awarded the 1995 American Medical Association Distinguished Service Award at the AMA's Annual Meeting in Chicago, Illinois, on June 18, 1995. The award, which includes a gold medal, is presented to individuals for meritorious services in the science and art of medicine.

Dr. Woodward's reaction to being chosen for the award was one of both pride and awe. But he insisted on sharing the glory. "I am very proud of our medical school, our hospital and my colleagues of the Medical and Chirurgical Faculty. I had wonderful teachers when I was in medical school; they taught us the importance of being thorough, always listening to the patients, and treating them as patients—not just as persons who had something wrong with them." Dr. Woodward has spent his life imparting these same principles to new generations of physicians.

The Carroll County native earned his medical degree from the University of Maryland School of Medicine in 1938. He graduated from Franklin and Marshall College in Lancaster, Pennsylvania, and before then attended Westminster High School. After completing an internship at the University of Maryland Hospital and a residency at the Henry Ford Hospital in Detroit, Michigan, Dr. Woodward entered the Army Medical Corps as a first lieutenant in early 1941.

Dr. Woodward's army career ultimately led to his development as an expert in infectious diseases. He was instrumental in reporting the first cure for typhus and typhoid fever just after World War II. As a member of the United States Army Typhus Commission, he was directly involved in combating epidemics of typhus in southern Italy, France, Germany, Egypt, and Aden. Despite his world-renowned reputation, however, Dr. Woodward insists, "I don't wish to be known as an infectious diseases expert, but rather as a physician who cared for patients and taught students." And that is what he has done for the past four and a half decades.

Dr. Woodward has been a doctor for 57 years. After the war, he returned to Baltimore, started a private



Dr. Woodward in his office at the University of Maryland School of Medicine.

Dr. Woodward's Acceptance Remarks

Naturally, I am grateful and beholden to the Trustees of the American Medical Association for this special recognition which is shared with pride and thanks to my institution, the University of Maryland School of Medicine and to my former students and colleagues of the Medical and Chirurgical Faculty—not only for their friendship and help, but for their contributions to the good of American medicine. Of course, my wife, Celeste, and family rank top for love, affection, and support.

Not everything is perfect in medicine today, but there is no need for apology. Since my early training in 1938, advances in medicine have been phenomenal. We were directed as interns to administer Mercurochrome intravenously to patients with bacterial endocarditis or take 10 ML of blood from a syphilitic paretic who had sustained 50 hours of malarial fever and transfer it to a new patient. How much hepatitis, unknown then, and what else did we cause?

Now, through medical progress, many killer infectious diseases are prevented or cured. Life expectancy in America in 1900 was about age 45; now it is well past 70. Much more is needed, such as answers to the ravages of arteriosclerosis, Alzheimer's disease, organ cancers, infertility, AIDS, dying with dignity, and others. Many of these will come, as will answers to ethical puzzles which the public and our professions must develop.

Medicine remains an ennobling profession. "Freedom from disease is said to be the first blessing." Physicians have repaid society for its generous sacrifices and will contribute more.

Thank you.



Dr. Woodward gives his acceptance speech to the AMA.

practice, and was appointed an assistant professor of medicine at the University of Maryland School of Medicine and Hospital in 1946; he was also an instructor in preventive medicine at The Johns Hopkins University School of Public Health. In 1948, he became an associate professor at Maryland and the first full-time clinical teacher in medicine there. Dr. Woodward then held the position of chairman of the Department of Medicine for 27 years, from 1954 to 1981, and was professor of medicine until 1983.

Under Dr. Woodward's leadership, many changes were made to the curriculum. He added clinical clerkships, initiated small group preceptorships between student and clinical teacher, organized a division of infectious diseases teaching and research unit, and developed various subspecialty divisions. As a result, clinical research was inaugurated and the department of medicine grew to be the largest in the school. Prior to his retirement, he taught every medical student who graduated from the University of Maryland School of Medicine during his tenure, except for those who attended from 1964 to 1965, when he was on a sabbatical. At the time of his retirement, it was speculated that he had taught half of Maryland's practicing physicians.



Dr. Woodward shares a moment with medical students Robert F. Corder and Mary G. Ripple at the University of Maryland.

Dr. Woodward is concerned about some of the changes that have taken place during his long career. Regarding our increasingly litigious society, he believes physicians who develop good doctor-patient relationships are less likely to be involved in litigation. But, he admits, the reasons behind lawsuits can be very complicated because "patients are often suing the system, an HMO, a hospital, rather than an individual per se." He adds, "This concerns all medical professionals; we are professional people, not a business. Society often perceives medicine as a business." Furthermore, in his opinion, "the way to achieve good managed care programs is through responsive, thorough, educated, and sympathetic care of patients. The process cannot be hurried. Some one person has to be in charge, responsible for making decisions."

Although technically retired, Dr. Woodward still sees patients, teaches students, and participates in research projects. He teaches a class in the sophomore year, then has some of the same students again in their junior year after they begin seeing patients. Often he demonstrates how to perform a physical examination, and says, "I try to teach them about the patient, about responsibility, to be thorough, and to think." In the senior year, he presents a seminar on ethics and dying. He says he will only continue to teach as long as students seem to be receptive and as long as he feels that what is being taught is relevant.

Despite a busy schedule, Dr. Woodward has found time to participate in governmental and public activity, such as the Armed Forces Epidemiological Board (its president for 14 years), the U.S. Japan Cooperative Medical Science Committee (30 years), the Veterans Administration Prisoners of War Advisory Committee, the NIH Cholera Advisory Board, and others. He proudly serves as a lifetime trustee of the Gilman School in Baltimore.

Dr. Woodward feels that he learned from some of the best—doctors such as Pincoffs, Carey, Shipley, Krause, and Friedenwald. He remarks, "Today at times we are perceived as treating an arrhythmia or a spastic colon instead of a patient with an arrhythmia or a spastic colon. I try to teach students about the patient, how things happen and why things happen. The wealth of medical knowledge today is great; such pioneers as Sir William Osler would have a hard time keeping up with everything today; but nonetheless, a good internist, a good primary care doctor, a good family doctor, does have general and practical knowledge."

Admired by his students, Dr. Woodward has been named the Student Council Faculty Awardee of the Year almost twenty times since 1966. "He is my father in medicine," said Dr. Donald T. Lewers, AMA Board of Trustee member and past president of Med Chi, in a 1993 interview for the *Maryland Medical Journal*. "Dr. Woodward instilled in me the love of medicine—not only the science of medicine, but the art of medicine," continued Dr. Lewers. He explained that Dr. Woodward taught him that "the art of medicine is dealing with people. It's the finite difference between medicine and other profes-



Dr. Woodward and his wife, Celeste, at the reception honoring their outstanding service to medicine.

sions." He credits Dr. Woodward with imparting that art to him and refers to Dr. Woodward as "a master."

Frequently asked to speak at the medical school graduation ceremonies, Dr. Woodward says that for his upcoming speech, "I will tell these graduates that they have something that cannot be taken away from them, the opportunity to improve someone's health." There are two points he says he always likes to stress during such talks—share life with a loving family (suggesting the students all marry and have four children "because that is a good number") and develop a hobby—and he practices what he preaches.

Dr. Woodward has been married to his wife, Celeste, for 57 years. "In my [medical school] class there were only three girls, and I married one of them." Dr. Celeste Woodward was a general internist, dermatologist, and emergency room physician prior to her retirement. The Woodwards have three children, all of whom are physicians; William and Craig are internists and Celeste Woodward Applefeld is a pediatrician. Celeste's husband, Mark, is a cardiologist.

Dr. Woodward was the youngest of four boys. He and his brother Lewis, a surgeon, went against their father's advice when they chose medical careers. He explains, "Father was a bit of a worrier; this was during the Depression." His father, a physician in Westminster, "worried at times as if he had caused the patient's illness. He was very conscientious." He continues, "I don't think he enjoyed medicine as much as I do, but he was a very fine doctor and contributed much to the public good."

Discussing his grandchildren, Dr. Woodward says four out of the nine may go into medicine. "The only thing is," he says, "they don't know it yet." But all kidding aside, Dr. Woodward says that neither he nor his wife ever pushed medicine as a career choice for their children. He is proud that they have a very loving, close family and that the children chose to follow him and their mother into medicine. He is equally passionate about his career choice. "I love the medical profession. I'd do it again."

Dr. Woodward admits, however, that "medicine can be demanding and an outlet alongside medicine is good." His outlet is his farm in Carroll County, where he raises ducks, pheasants, peacocks, and swans. "I like to watch things grow. I don't shoot them, I just release them." He visits the farm on Sundays where his son Bill lives.

"What I relish about my life more than anything else is my family," says Dr. Woodward. He speaks of his family, and particularly his wife, with sincere fondness, recalling how special family vacations were to him. "I love the mountains, my family loves the shore. We always compromise and go to the shore."

VIVIAN SMITH
Ms. Smith is assistant director of communications at Med Chi. ■

The role of restriction fragment length polymorphism in the public health and epidemiology of tuberculosis: an update for Maryland physicians

Udo Buchholz, M.D., M.P.H.

At the time this paper was written, Dr. Buchholz was completing his master's degree in public health at The Johns Hopkins University School of Hygiene and Public Health.

Maryland physicians should be aware of discoveries in molecular biology that are important in the diagnosis, case follow-up, and epidemiology of tuberculosis. Although the number of tuberculosis cases in the United States as a whole rose during the period 1984 to 1992, Maryland and Baltimore were able to stem the tide, primarily by case management using directly observed therapy. Recent political decisions (such as the elimination of the Disability Insurance and Loan Program) and the increasing prevalence of AIDS cases in Maryland, however, may lead to an increase in the number of homeless people, who are not only at high risk for tuberculosis, but have difficulty cooperating with a tuberculosis control program.

Until a few years ago, it was thought that the United States could eliminate tuberculosis by the year 2020. In view of the HIV epidemic, the rising number of homeless people, and the emergence of multiple drug-resistant tuberculosis, achievement of that goal is now doubtful. Big cities like Baltimore will be challenged more by control than by elimination of tuberculosis, giving rise to the need for more specific testing modalities.

In recent years, molecular biological techniques such as polymerase chain reaction and restriction fragment length polymorphism (RFLP), also known as DNA fingerprinting, have been applied successfully to the rapid diagnosis of tuberculosis and the identification of specific strains of *Mycobacterium tuberculosis.*

RFLP in tuberculosis strain differentiation

Highly specific restriction endonuclease enzymes cut the DNA of tubercle bacilli at certain typical sites. The enzymes are able to recognize these sites by the sequence of nucleic acid base pairs where they insert and

cleave off the DNA. In a following step, the DNA is separated by gel electrophoresis in which the electric field "pulls" the negatively charged DNA molecules through a porous agarose gel.[1] Small DNA molecules move faster through the gel than large ones. The resulting bands are made visible by means of a fluorescent stain that reveals the unique pattern that led to the name *DNA fingerprinting*. See **Figure 1**.

For mycobacteria, a restriction fragment technique was developed using the insertion sequence IS 6110, which provides a means to differentiate various strains of *Mycobacterium tuberculosis*.[2] Van Emden and colleagues[3] proposed a standardized technique that makes use of both the number and genomic position of IS 6110 to generate strain-specific patterns that are comparable among different laboratories.

Mycobacteria persist in the body for a long time, even after treatment is started and especially in cases of recovery failure due to noncompliance with treatment. Thus, it was important to determine if the fingerprint pattern of the isolate of one patient remains stable over time. Cave and coworkers[4] confirmed the stability of RFLP patterns for a period of up to 4.5 years despite chemotherapy or a change of the mycobacterium population due to the evolution of drug resistance.

Practical applications

Until recently, there was general agreement among epidemiologists that secondary (or postprimary) infection of tuberculosis occurs in about 90% of cases due to reactivation from a primary site. As late as 1990, Haque[5] stated in a literature review that secondary tuberculosis results only "rarely" from reinfection (rather than reactivation). It must not be forgotten, however, that this was only true because until 1984, the opportunities for new infection had continued to decrease due to effective diagnosis and case management. A 1958 analysis showed that the case rates among reactors to PPD (indicating reactivation) gained more weight over time as the case rates among nonreactors decreased (indicating new infection).[6] Thus, the proportion of cases due to infection or reinfection will increase in situations where infection rates are high. Indeed, within the last few years, several studies using fingerprint methods showed again that, at least in certain settings, the proportion of newly infected or reinfected tuberculosis cases may be as high as 40%. For example, the isolates of 473 patients in a study in San Francisco were analyzed using a DNA fingerprint pattern technique.[7] Patients with the same patterns were grouped in "clusters" because it was reasoned that they had active tuberculosis as a result of recent transmission, which was the case for 191 patients (40.3%) who could be placed in 44 clusters. In a study in New York, the isolates of 38% of the patients were identical to those of at least one other patient.[8] In a study in Berne, Switzerland, it was possible to link the patterns of 28% of the patients to another person.[9] In the three studies cited, the risk factors (some closely correlated) associated with being in a cluster were

- Hispanic or black race;
- HIV infection;
- infection with drug-resistant tuberculosis;
- low-income household;
- homelessness;
- alcoholism/drug abuse.

The immune-depressing qualities for several of the above factors are either well described or very plausible. The above findings suggest that there is not only an increased risk for the reactivation of a latent infection, but an increased risk for infection or reinfection from an external source and progression to manifest disease.

Two studies show how rapidly and easily tuberculosis can be spread among HIV-infected people. In one study, an outbreak in a housing facility for HIV-infected people is described. In 12 residents who developed tuberculosis, RFLP analysis of the isolates linked the residents to each other, but not to 2 other residents who were treated for tuberculosis 6 months earlier and could be excluded by RFLP as the source of the epidemic. The first of the 12 patients subsequently was implicated in spreading the infection.[10] In the second study, an outbreak of active tuberculosis occurred in 18 HIV-positive people, six of whom could be linked together. Their only common exposure was in three bars that they had patronized.[11]

Implications

- The use of RFLP could help researchers determine how microepidemics might arise due to properties of specific strains of the tubercle bacillus, such as high virulence.
- RFLP may be helpful in estimating the proportions of reinfection to reactivation in specific situations. In certain high risk groups, the rate of recent infection may be more than 40%.
- By enabling epidemiologic investigators to identify groups of people (clusters) who are infected by the same source, RFLP can help identify the index case and can lead to re-evaluation of the relevant modes of transmission, especially in HIV-infected patients. RFLP is used in Maryland by the state health department for assistance in tuberculosis control.

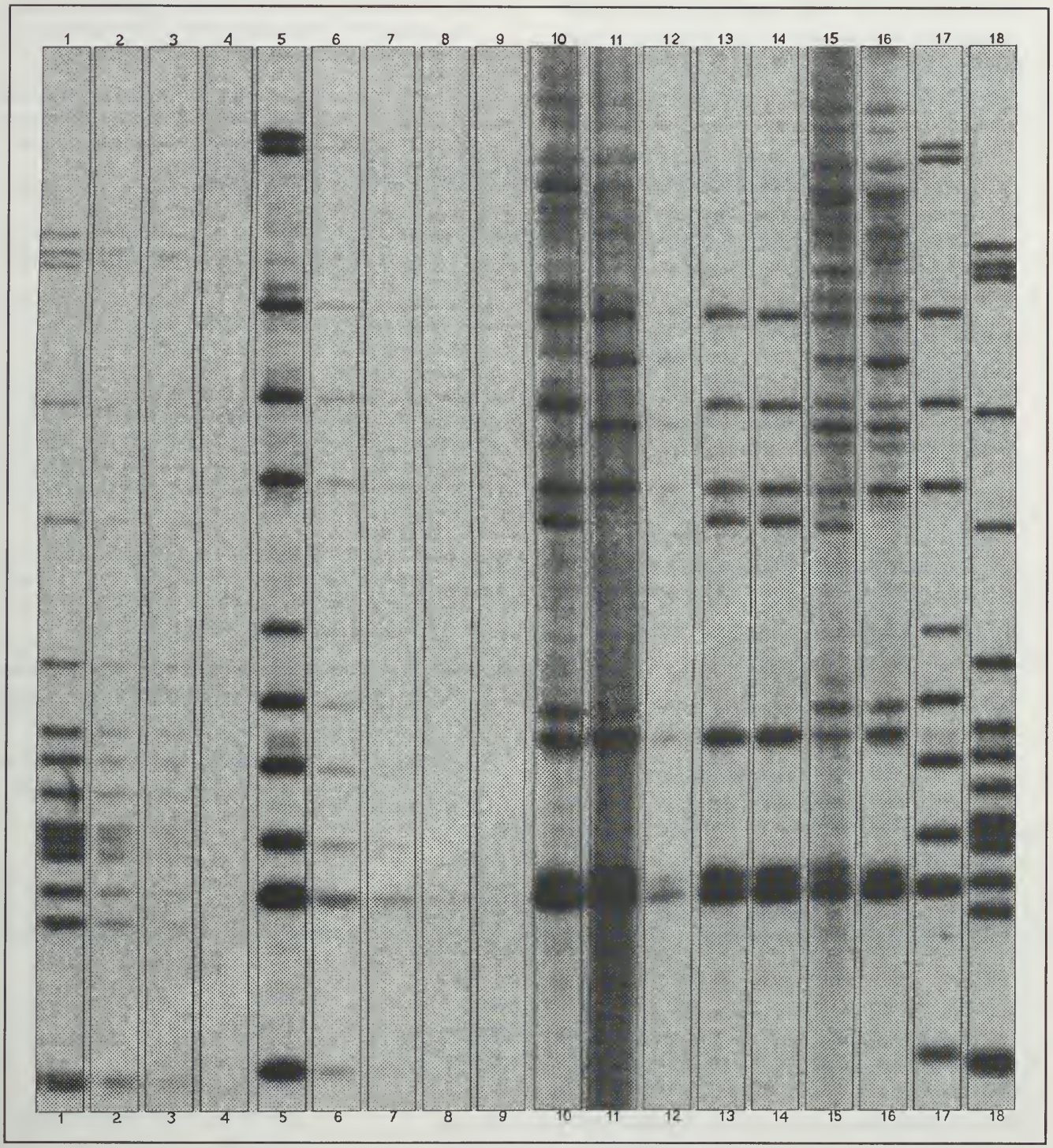


Figure 1. DNA fingerprints of mycobacterial DNA

The bands in lanes 1 to 3 are identical, as are the bands in lanes 13 and 14. Thus, lanes 1 to 3 and 13 and 14, respectively, belong to isolates from patients infected with the same strain. The other lanes contain mycobacterial DNA from other species and/or strains.

Source: *Mycobacterial Laboratory, Centers for Disease Control, Atlanta, Georgia.*

- The high rate of reported noncompliance with drug therapy (as was the case in New York a few years ago), which leads to multiple drug-resistant strains of *Mycobacterium tuberculosis,* should prompt reconsideration of the current public health and political measures to control tuberculosis. Inflexible continuation of policies may have deleterious consequences, not only for high-risk groups, but for the general population because, as Genewein and colleagues[8] observed, the bacillus will be "spilled over."
- Like the supervised treatment program in New York, which achieved completion rates as high as 95%,[12] the Baltimore program promoting directly observed therapy has been quite successful. The New York program, however, did not include homeless people because they defy the routine of daily visits by health care workers.
- Prolonged, possibly mandatory hospitalization may have to be considered[12] both to avoid the development of more multiple drug-resistant tuberculosis and to protect highly susceptible people. Such programs could be of value for the public's health in Maryland.

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NATIONAL PUBLIC HEALTH SURVEILLANCE LIST OF NOTIFIABLE DISEASES, 1995

- AIDS
- Anthrax
- Botulism
- Brucellosis
- Chancroid
- *Chlamydia trachomatis*
- Cholera
- Coccidioidomycosis
- Congenital rubella syndrome
- Cryptosporidiosis
- Diphtheria
- *Escherichia coli* 0157:H7
- Gonorrhea
- *Haemophilus influenzae*
- Hantavirus infection
- Hemolytic uremic syndrome
- Hepatitis A
- Hepatitis B
- Hepatitis, non-A, non-B
- Invasive group A streptococcal infections
- Legionellosis
- Leprosy
- Lyme disease
- Malaria
- Measles
- Meningococcal infection
- Mumps
- Pertussis
- Plague
- Poliomyelitis
- Psittacosis
- Rabies, animal, human
- Rocky Mountain spotted fever
- Rubella
- Salmonellosis
- Shigellosis
- *Streptococcus pneumoniae* (drug-resistant)
- Syphilis
- Tetanus
- Toxic-shock syndrome
- Trichinosis
- Tuberculosis
- Typhoid fever
- Yellow fever

Health problems of Maryland's migrant farm laborers

Vivian Go, M.A., M.P.H., and Timothy Baker, M.D., M.P.H.

From The Johns Hopkins University School of Hygiene and Public Health, where Ms. Go is a research assistant and Dr. Baker is a professor in the department of international health.

ABSTRACT: *The health problems of Maryland's agricultural migrant labor force are presented for the information of Maryland's health care providers. Maryland's problems are placed in the context of U.S. and worldwide migrant labor practices.*

Background

Human migration to follow food supplies is older than recorded history. Short distance migrations of hunter-gatherer societies occurred in Africa long before settled agriculture was established along the Nile River and the Tigris-Euphrates basin. The major migrations of early Proto-Indian people, following the food supply across the Bering Sea land bridge, led to the colonization of the Americas.

Worldwide. Today, agricultural migrations are of more limited scope, but exist in all parts of the world. Examples include the importation of Haitian cane cutters to the fertile sugar cane fields of the Dominican Republic. These migrant workers, herded into trucks, housed in crowded, inadequate shelters, underpaid and overworked, are not atypical of many migrant laborers. In Indonesia, labor gangs travel through Java at the rice harvest season, negotiating with land owners for contracts to harvest rice. Although the gangs have a high percentage of female laborers, they aggressively drive out local workers. In the Amazon Basin, migrant laborers were imported to tap wild rubber trees in the rubber boom of the early 1900s. The "Army of the Amazon" was brought in to meet the demand for rubber during World War II, when the rubber plantations in Malaysia and Indonesia were under Japanese control. Today's migrant labor in the Amazon includes both homesteaders and casual, landless laborers from the impoverished, drought-stricken northeast.

Table 1. Eastern Shore migrant farm labor population, 1993[1]

County	Number of workers
Caroline	223
Dorchester	42
Kent	95
Queen Anne's	163
Somerset	1242
Talbot	17
Wicomico	162
Worcester	43
Total	1987

In addition to agricultural labor, modern times have brought the phenomenon of industrial migrant labor. "Guest" laborers include Turks in Germany; Algerians, Tunisians, and Moroccans in France; and Yemeni laborers, Korean construction workers, Egyptian and Pakistani clerical workers, and British nurses and doctors in Saudi Arabia and other oil rich countries.

Throughout history, major construction projects have called for large numbers of migrant laborers: Chinese to build the railroads in the western United States; South Indians for canal construction in Burma; French engineers and laborers for the first attempt to create a canal through Panama; laboras from Trinidad and Barbados; engineers from the United States to build the Panama Canal; and the Japanese use of prisoner-of-war "slave" labor to construct the "Bridge on the River Kwai" railroad from Bangkok to Burma. The impact of disease on these migrant workers is well known: yellow fever and malaria devastated the French in Panama, and the construction of the railroads in Thailand/Burma and Madeira-Mamore in the Amazon were said to cost "for every [railroad] tie a life."

United States. In the United States, the major transition from "hired hands" to migrant labor occurred during and following the Depression. There were three major "streams" of migrant farm laborers. The West Coast stream was made up mainly of Mexicans, but included dust bowl refugees from Oklahoma; Indians (from India); native African Americans; Filipinos; and even some Chinese. The Central stream was made up primarily of Mexicans and native-born Spanish Americans. The East Coast stream initially was made up of native African Americans, who later were supplemented by Haitians, Mexicans and Central Americans. The worker shortages of World War II led to the establishment of the official Bracero Program for the importation of Mexican migrant farm laborers. The program had its antecedents in the earlier, unofficial use of migrant labor in Imperial County, California, to establish irrigation projects and harvest crops.

The total number of migrant and seasonal farm workers plus dependents is slightly more than 4 million—not quite 2% of the total U.S. population. However, they account for well over 2% of the U. S. health problems. California is the largest employer of migrant and seasonal farm workers—more than 1 million workers and dependents, which is more than double the number in Texas, the next largest employer. Other large employers are Florida, North Carolina and Washington State.

Maryland's migrant laborers

Data included in the current report were obtained from county health officials and the Delmarva Rural Ministries, which is the major Eastern Shore health provider for migrant workers.

Maryland may have as many as 4000 migrant and seasonal workers. Estimating the number of migrant and seasonal farm workers is far from an exact science. The U.S. Department of Health and Human Services has attempted to estimate the overall number of migrant farm workers in 1990. Estimates were carried out for states by state health agencies or research groups under contract. Not only are the methods for estimation of questionable accuracy, but estimators occasionally made major mistakes in calculations. The estimate of 4000 that we report is a corrected figure provided by the U.S. Public Health Service. County estimates provided by the Maryland Governor's Commission on Migratory and Seasonal Farm Labor in 1993 indicate lower total numbers.

Washington County annually employs 130 migrant workers and 260 seasonal agricultural workers, primarily for fruit growing. However, the major employers are counties on the Eastern Shore (see **Table 1**), where migrant workers are used primarily to harvest truck farm crops such as tomatoes,

Table 2. Ethnic composition of Eastern Shore migrant farm labor, 1993[1]

Group	Number	Percent of total
African American	84	4
Haitian	172	9
Mexican	1588	80
White	11	0.6
Central American	132	7
Total	1987	100

Table 3. Major health problems among Eastern Shore migrant farm workers, 1994

Problem	Perinatal	Pediatric	Adolescent	Adult	Geriatric
Dental	14	77	9	198	4
Skin/dermatologic infections	--	13	2	54	6
Gynecologic/family planning	--	--	10	36	--
Well child/immunizations	55	92	--	--	--
Muscular/skeletal	--	--	4	--	7
Otitis media	--	15	--	--	--
Epidemiologic contact hepatitis	4	--	--	--	--
Respiratory	--	18	--	--	3
Hypertension	--	--	--	47	4
Diabetes mellitus	--	--	--	38	--

cucumbers, asparagus, squash, watermelons, and cantaloupes. The migrant labor season begins in March and ends in September; the peak season is July and August.[1]

On the Eastern Shore, 80% of migrant workers are Mexican; 9% are Haitian refugees; and 7% are Central American migrants, both legal and illegal (**Table 2**).[1]

The major health problems of migrant farm laborers, as identified in the Delmarva Rural Ministries clinics, are summarized in **Table 3**. The perinatal category refers to prenatal care for mothers and includes prenatal health education, dental diagnosis and treatment, and referrals to the county health department. The pediatric category comprises children aged 0 to 11; the adolescent category, children aged 12 to 19; the adult category, adults aged 20 to 64; and the geriatric category, adults aged 65 and older. Sexually transmitted diseases (STDs) were recorded as a separate category that is not listed among the ten major migrant farm worker health problems shown in Table 3.

Injuries. The literature indicates that agriculture has one of the highest rates of work-related fatalities of all industries.[2] Children aged 15 or younger represent 6% to 10% of all farm-related fatalities in this country; in some states, 25% of all farm-related injuries involve children.[2,3] These studies are based on data from midwestern states where there is a high concentration of migrant and seasonal farm workers. Although injuries did not appear in the Delmarva clinic reports, they are a major problem. According to our sources, migrant farm workers are treated for injuries in emergency rooms, but are not explicitly identified as migrant workers.

Pesticides. The literature suggests that a high proportion of agriculturally related pesticide poisonings involve migrant farm workers.[4-6] Although some reported dermatitis cases in Maryland may be attributable to pesticides, our sources reported no cases of pesticide toxicity in Maryland migrant farm workers. Pesticides may be a problem, however, if proper precautions are not taken.

Table 4. Major health problems among migrant farm workers' children, Somerset County

Problem	Average number of episodes in past 6 years
Dental	36
Ear/eye/nose/throat	33
Communicable diseases	29
Anemia	6
Injuries	5

Somerset County

There are 14 migrant worker camps in Somerset County, an area that is primarily farmland. The majority of workers are Hispanics (Mexican), a small percentage are Haitians, and an even smaller percentage are African Americans. The workers tend to move up the East Coast from Florida, staying in Somerset County for four to six weeks before moving on to Pennsylvania. The peak migrant season is July 1 to August 14.

Migrant workers are not seen as a priority of the county health board. Community perceptions vary. Farmers believe the economic benefits of migrant farmers outweigh the resources invested in migrant health and education. Other community members, however, feel that "migrants are taking away from the county pot of money." One source spoke of being approached by several different community members who complained, "We don't even have those services, why give them to the migrants?" These feelings are subdued, not aggressive. One county health authority, who has been working with migrants for 10 years, feels that positive changes in health services have occurred over time.

Physical examinations and health screenings revealed that the leading health problems in migrant children aged 5 to 15 were dental problems, ear/eye/nose/throat problems, and communicable diseases such as pediculosis and upper respiratory infections. **Table 4** summarizes the major health

problems of migrant farm workers' children by averaging the number of episodes in each category per year from 1989 to 1994.

Caroline and Kent counties

In Caroline County, the majority of migrants are Haitians who are devoted to truck farming. They stay in the county only about two months before moving north. Each year there is a different group of migrants, a factor that adds to the unstable nature of the group. According to our source, transience is at the root of their health care problems.

Kent county's migrant population consists primarily of workers from Mexico who work in farm nurseries. Because the group remains in Kent County for whole seasons, they have year-round housing and better access to the health system. Our source identified STDs, tuberculosis, and farm-related injuries as the primary health problems affecting migrant farm workers in the two counties.

Dorchester, Queen Anne's, Talbot, Wicomico, and Worcester counties

In Dorchester County, migrant farm workers most frequently visit the county health clinic for tuberculosis treatment and pregnancy tests. According to our source, the major barriers to health education and access to health care are culture and language. Physicians are often unwilling to take migrant patients because of the language barrier and because they are temporary residents. If funds were available, the migrant community would benefit from health care providers who are Spanish-speaking and preferably from Mexico (the mother country of the majority of migrants).

The migrant population in Queen Anne's and Talbot counties is relatively small and consists of primarily Hispanics engaged in poultry-raising and processing. Because there are no licensed migrant camps in Wicomico or Worcester counties and the numbers of migrant farmers are relatively small, little data are available on this population. According to a county health department source, the major health concerns of Worcester's migrant population are STDs, maternal and child health, and substance abuse.

Conclusion

Migrant and seasonal farm laborers are an important part of Maryland's agricultural production, primarily affecting the Eastern Shore. Concerns with their health are based not only on moral and charitable grounds, but on the fact that their productivity is important in the farm economy of Maryland. Volunteer work by health providers during the summer is welcomed by health provider agencies. Indeed, Queen Anne's County Health Department was "unable to offer an evening clinic [in 1993] because of insufficient volunteer staff." Officials in Somerset County expressed a need for volunteers to provide dental services, particularly for adult migrants. Spanish or Creole speaking ability and a sensitivity toward Mexican, Haitian, and Central American cultures would be especially helpful for both clinic-based and outreach activities.

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Acknowledgement

In addition to the Delmarva Rural Ministries, the following sources were extraordinarily helpful in providing information on migrant farmers in their counties: Caroline and Kent counties, Dr. John Grant; Queen Anne's and Talbot counties, Dr. John Ryan; Dorchester County, Jackie Smith, R.N.; Somerset County, Colleen Parrott, R.N.; Wicomico County, Brenda Williams, R.N.; Worcester County, Rebecca Shockley, R.N. ■

Case report: atrial coiling of permanent pacing elctrode

Mahmood Alikhan, M.D., F.A.C.C., and James H. Biddison, M.D., F.A.C.C.

Dr. Alikhan is an interventional cardiologist with Clinical Associates, and Dr. Biddison is a cardiologist in the Towson area.

Reprints: *James H. Biddison, M.D., 7401 Osler Dr., Towson, MD 21204*

Unanticipated coiling of endocardial atrial and ventricular permanent pacing leads is an infrequent problem. Commonly accepted methods of securing pacing leads are designed to prevent not only migration or dislodgement, but lead fracture. Coiling is a radiologic diagnosis that may not be apparent clinically unless the result is pacemaker malfunction. Prior to the current case, reported mechanisms of coiling have included suture problems at the lead insertion site and "twiddling" (i.e., lead movement caused by the patient's manually rotating the pacemaker generator within the subcutaneous pocket after implant). Various types of retaining sleeves and sutures have been used to secure pacemaker leads without causing lead fracture. The following case report documents another mechanism of lead coiling not previously described.

Case report

A 60 year-old man with insulin-dependent diabetes and congestive heart failure was hospitalized with bronchopneumonia. Six years earlier, he had undergone aortic valve replacement for aortic stenosis. Left bundle branch block and atrial fibrillation had been present on the electrocardiogram (ECG) for the past six years.

The patient developed symptomatic, high-degree atrioventricular block with syncope. A VVIR Medtronic 8424 generator and 58 cm bipolar endocardial lead were implanted with relative ease. A percutaneous left subclavian vein approach for lead insertion was used in the midclavicular line. The lead was secured to the surrounding fascia with two #2-0 silk sutures placed circumferentially over a retaining silastic sleeve located at the lead entry site. The remaining distal lead was placed under the pacemaker generator in a subcutaneous pocket. A chest roentgenogram taken the day after the pacemaker was implanted showed satisfactory placement of the lead throughout its course to the right ventricular (RV) apex (**Figure 1**).

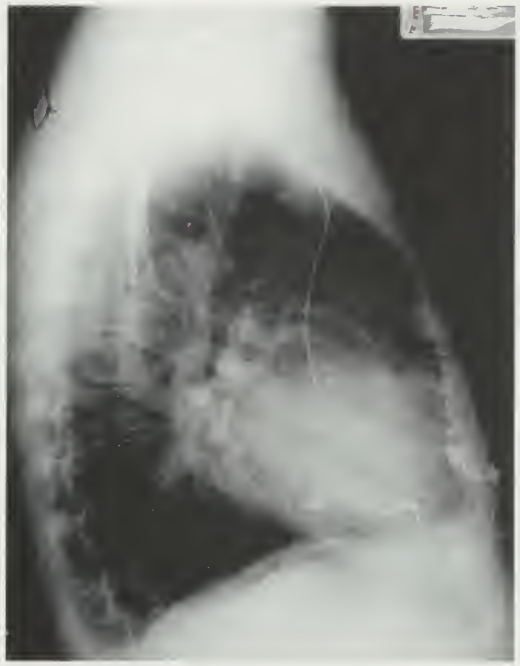


Figure 1. The day following implantation, lead placement appears satisfactory.

Eight weeks later, the patient developed a productive cough and fever. He described several violent paroxysms of coughing, but did not experience any change in the location of the pulse generator. He was not a "twiddler." A chest roentgenogram showed a right lower lobe pneumonia. As an incidental finding, a large loop of endocardial lead was present in the right atrium, without displacement of the distal lead at the RV apex (**Figure 2**). Appropriate sensing and pacing were observed on the ECG. The patient was discharged after resolution of the pneumonia. Appropriate pacing continues at 18 months of follow-up. Pacemaker telemetry showed no malfunction.



Figure 2. Endocardial lead looped in the right atrium.

Discussion

Short- and long-term complication rates for endocardial lead placement, including lead fracture, displacement, perforation, and infection, are low.[1] Lead coiling after insertion has been described only rarely, with both atrial and ventricular electrodes, and has been based on two possible etiologies. The first involves suture problems at the insertion site. To avoid insulation failure and/or lead fracture by direct pressure of a suture over the catheter, a retaining sleeve is used to secure the lead to the surrounding fascia. Loose or broken sutures would allow additional wire to slide and coil in the heart. An absorbable suture could have a similar long-term result; hence, the use of multiple nonabsorbable sutures has been recommended.[2,3]

Another possible mechanism is the "twiddler's syndrome," in which the patient rotates the pacemaker generator in its pocket.[4] Twiddling could result in intracardiac coiling of the lead or, conversely, retraction and displacement of the lead so that the unit is no longer functional. A suture hole is provided through the header of the pacemaker pulse generator to secure it to the chest wall, which helps prevent twiddling.

In the current case, the patient was not a twiddler and the suturing technique followed currently recommended guidelines (i.e., multiple interrupted nonabsorbable sutures over a retaining sleeve). We postulate that the intracardiac coiling was due to the vigorous inspiratory effort of repeated coughing paroxysms.

We are unaware of any similar cases and can suggest no solutions to the problem. Perhaps future technological advances will alleviate the problem. In the meantime, we would like to alert other clinicians to the possibility of atrial coiling in pacemaker patients with prolonged cough of any etiology and suggest that in such patients, a delayed, follow-up chest roentgenogram may be important.

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A Clinical Moment with Endocrinology and Metabolism

Laparoscopic adrenalectomy

Dear Doctor:
I have been treating a 34-year-old woman who developed marked hypertension during pregnancy. Following delivery, she was noted to have progressive weakness, persistent hypertension, violaceous abdominal striae, hirsutism, and easy bruisability. Cushing's syndrome was demonstrated by elevations in both her morning and evening cortisol levels. What should I do next?

The most important aspect in making the diagnosis of endogenous Cushing's syndrome is a high index of suspicion. Patients who present with symptoms and signs suggestive of Cushing's syndrome should undergo a screening test to rule out increased production of glucocorticoids. A convenient laboratory study is measurement of urinary-free cortisol (UFC) and 17-hydroxycorticosteroids in a 24-hour urine specimen. Elevated values confirm the diagnosis and a more detailed evaluation is warranted.

Endogenous Cushing's syndrome is either adrenocorticotropic hormone (ACTH) dependent or ACTH independent. The two forms of ACTH-dependent Cushing's syndrome are: 1) Cushing's disease (the most common form of endogenous Cushing's syndrome), and 2) the ectopic ACTH syndrome. Both forms of non-ACTH-dependent Cushing's syndrome are adrenal in origin and are caused by either an adrenal adenoma or an adrenal carcinoma. Therefore, by measuring plasma ACTH one can, in most cases, distinguish these subsets. If the ACTH level is elevated, the etiology is most likely a pituitary abnormality or, less commonly, an ectopic tumor. If the ACTH level is suppressed, however, an adrenal neoplasm secreting high levels of glucocorticoid should be suspected.

The low/high dose dexamethasone suppression test (Liddle test) is still a useful tool to distinguish the etiology of Cushing's syndrome. Although it is somewhat cumbersome, and in some institutions has been replaced by the overnight dexamethasone suppression test, it has the ability to confirm Cushing's syndrome and give strong etiologic support. Adrenal tumors and ectopic ACTH-producing tumors do not suppress with either low- or high-dose dexamethasone. In approximately 85% of patients, however, ACTH-secreting pituitary adenomas suppress with high-dose dexamethasone.

Anatomic imaging studies play an important role in the evaluation of patients with Cushing's syndrome. A magnetic resonance image (MRI) of the pituitary is essential for patients with presumed Cushing's disease. In patients with suppressed ACTH levels, either an abdominal MRI or computed tomogram of the adrenal glands is required.

The current patient had suppressed ACTH levels and was noted to have a 3 cm left adrenal mass on an abdominal MRI scan. Her right adrenal gland was of normal size. This information confirmed that the etiology of her Cushing's syndrome was almost certainly due to excessive cortisol production from the left adrenal gland, which in turn suppressed her endogenous ACTH level. Had she had an ACTH-dependent cause of Cushing's syndrome, she would most likely have had bilateral adrenal hyperplasia. In addition, the fact that her adrenal mass was only 3 cm in size suggested that it was a benign process, since malignant adrenal tumors are almost always larger than 5 cm.

The patient and her family were counseled about the etiology and treatment of Cushing's syndrome, and she elected to undergo a laparoscopic left adrenalectomy. The procedure was performed under general anesthesia utilizing a transabdominal flank approach to gain exposure to the left adrenal gland, located in the retroperitoneum. The procedure was accomplished with minimal blood loss, and the

"A Clinical Moment with Endocrinology and Metabolism" is a regular feature of *Maryland Medical Journal*. If you are interested in submitting a case for publication consideration, or have a clinical question that you would like to see discussed, please contact the department editor: James H. Mersey, M.D., 6565 North Charles St., Suite 411, Baltimore, MD 21204.

adrenal gland was extracted in a plastic bag via one of the four laparoscopic port sites.

The patient tolerated the procedure well, had clear liquids the night of surgery, and was discharged the following day. She required minimal postoperative analgesia and returned to full employment within seven days. All symptoms and signs of Cushing's syndrome resolved.

Laparoscopic adrenalectomy is a natural outgrowth of the newly developed laparoscopic techniques. It results in decreased hospitalization and far less patient discomfort than that associated with open techniques. All adrenal tumors, with the exception of adrenal carcinomas and poorly controlled pheochromocytomas, can be considered for laparoscopic extirpation.

ROBERT UDELSMAN, M.D.
Dr. Udelsman is an associate professor of surgery and director of endocrine surgery at The Johns Hopkins University School of Medicine.

JAMES H. MERSEY, M.D.
Editor

Suggested reading

Gagner M, Lacroix A, Bolete E. Laparoscopic adrenalectomy in Cushing's syndrome and pheochromocytoma. *N Engl J Med* 1992;327:1083.

Takeda M, Go H, Imai T, Nishiyama T, Morishita H. Laparoscopic adrenalectomy for primary aldosteronism: report of ten cases. *Surgery* 1994;115:621–625.

Reprints: *Robert Udelsman, M.D., Blalock 688, Johns Hopkins Hospital, 600 N. Wolfe St., Baltimore, MD 21287* ■

WHO NEEDS VACCINATIONS?

- **Hepatitis B**
  - health care workers
  - injectable drug abusers
  - homosexual males
  - household members/sexual partners of hepatitis B carriers
  - people with multiple sexual partners
  - public safety workers (police, firefighters, etc.)
  - clients/staff of group homes, workshops, and schools for the developmentally disabled and mentally handicapped
  - travelers to Thailand
- **Influenza**
  - health care workers
  - residents/staff of nursing homes/chronic care facilities
  - household members of those at high risk for influenza
  - public safety workers (police, firefighters, etc.)
  - clients/staff of group homes, workshops, and schools for the developmentally disabled and mentally handicapped
- **Measles**
  - health care workers (2 doses unless born before 1957)
  - college/technical school students (2 doses since birth)
- **Pneumococcal disease**
  - residents of nursing homes/chronic care facilities
- **Rabies**
  - veterinarians/animal handlers
  - forest rangers
  - field workers
  - Peace Corps volunteers
- **Anthrax**
  - animal hide workers
  - unprocessed wool workers
- **Hepatitis A**
  - child care workers
  - workers with the mentally handicapped
- **Yellow fever**
  - travelers to South America, Africa

In Memoriam



Richard D. Bauer, M.D.

Our medical community lost a friend and real champion for good medical care when Richard D. Bauer, M.D., the 120th president of the Medical and Chirurgical Faculty of Maryland, succumbed to cancer June 2, 1995, at his home in College Park. He was 74.

Dick was born and raised in Philadelphia, Pennsylvania. His father, Edward T. Bauer, held the chair of professor of pediatrics at Jefferson Medical College for 25 years. Dick received his preparatory education at the William Penn Charter School in Philadelphia, where his ability as a soccer player earned him a scholarship to Haverford College. While completing his premedical studies at Haverford, Dick received the honor of being named All American in soccer. He attended Jefferson Medical College and upon graduation became the eighth generation of doctors in his family.

After military service, Dick returned to Jefferson Hospital for a residency in hematology. Shortly thereafter, Dr. Aaron Deitz, a well-respected general practitioner in Hyattsville, Maryland, contacted Jefferson Medical College, which was also his alma mater, seeking a young physician to join him in practice. To our good fortune, Dick was offered and accepted the position and moved his family to Maryland in 1949. After many years of enjoyable and successful practice of medicine with Dr. Deitz, Dr. Bauer established his own solo practice of family medicine in nearby Adelphi, Maryland. Dick retired from medical practice in 1984.

Dick was active on the medical staff of Prince George's Hospital Center and served as chief of staff from 1962 to 1984. After he retired from practice, he maintained his interest and involvement in medicine as a consultant for quality of care at the National Medical Advisory Service Inc., in Bethesda. He continued in this position even during his terminal illness.

For 40 years, Dick was an active member of Prince George's County Medical Society and served as its president in 1962. He became active in the medical affairs of the state of Maryland and served as the first Med Chi president from Prince George's County (1967-1968). Dick's consuming medical career was rivaled by his devotion to his family: his wife, Vandy, three charming daughters, and six grandchildren. The Bauer home was always open for enjoyment and was full of fun, love, and music. Dick was also active in community life and pursued many interests. He was the founder of the Adelphians, a community theater group, and directed, staged, and acted in numerous plays. He was a member of St. Andrew's Episcopal Church in College Park.

Dick will be remembered fondly by his many patients and friends, as well as by those of us who had the opportunity to work with him in delivering patient care. Testimonials by his patients confirm that Dr. Bauer was a true family doctor who touched and influenced the lives of many people. He had that beautiful blend of being both a patient's doctor and a doctor's doctor. We will miss him.

WILLIAM A. HOLBROOK, M.D.

Luis Cuza, M.D., a family doctor formerly of North East, Maryland, died April 9, 1995, of complications from Alzheimer's disease at the Alzheimer's Care Facility in Bowling Green, Kentucky. Born in Havana, Cuba, Dr. Cuza was a graduate of the Medical School of the University of Havana. He practiced medicine in Cuba until 1958, when he moved his practice to Cecil County. Dr. Cuza was on the medical staff of Union Hospital from 1968 to 1986, and made house calls until his retirement. He was 83.

W. Drummond Eaton, Sr., M.D., a 40-year member of Med Chi, died May 28, 1995, of lung failure at his home in Greenspring Valley, Maryland. A native of Truro, Nova Scotia, Dr. Eaton earned his medical degree at McGill University and completed his internship and residency at The Johns Hopkins Hospital. He began practicing obstetrics and gynecology in 1942. A member of the medical staff at the Women's, Union Memorial, and Johns Hopkins hospitals and the Greater Baltimore Medical Center, Dr. Eaton also had a private practice on Chase Street in Baltimore and later in Towson and Timonium. Before his retirement in 1984, he taught at The Johns Hopkins University School of Medicine and helped in the planning and development of GBMC. Dr. Eaton was a member of many professional and community organizations. He was 83.

Leo J. Gaver, M.D., a retired family practitioner, died of leukemia on May 27, 1995, at his home in Myersville. A native of Church Hill, Maryland, Dr. Gaver graduated from the University of Maryland School of Pharmacy and the University of Maryland School of Medicine, receiving his medical degree in 1939. Following five years in the Army during World War II, Dr. Gaver practiced medicine in Baltimore from 1946 until his retirement in 1976. He was a member of several professional and community organizations. Dr. Gaver was 81.

John R. Marsh, M.D., a vascular, thoracic, and general surgeon, died of lung cancer at his home in Fairplay, Maryland, on May 26, 1995. Dr. Marsh began his practice in Hagerstown in 1967, became the senior physician at the Hagerstown Surgical Clinic, and in 1994, was appointed medical director of the Robinwood Surgery Center. In 1996, the John R. Marsh Cancer Treatment Center will be added to the surgery center and named in his honor. In addition, a medical lecture series with his name will be developed by the Washington County Hospital for health professionals. Dr. Marsh had worked to standardize patient care by emergency technicians and was one of the first instructors to train cardiac rescue technicians, now called paramedics. Recently, Dr. Marsh had been given a lifetime service award from the Maryland Institute for Emergency Medical Services System (MIEMSS). He was 63.

No additional information was available at press time for the following members:

Leon Ashman, M.D.
Baltimore City ..... May 6, 1995

Louis F. Galdieri, M.D.
Montgomery County ..... May 13, 1995

John E. Harvey, M.D.
Affiliate ..... February 1, 1994

Debra C. Kalter, M.D.
Montgomery County

Ilse Kamm, M.D.
Carroll County

Homayoon Taavon, M.D.
Baltimore City ..... March 1994

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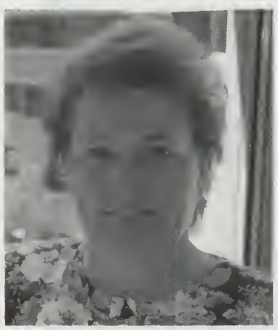
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Registration deadline is October 20. For more information or to register, call Miriam Scherer at **(302) 366-1929.**

AMA, AAFP, AOA, CEU credits

Minutes of the Meeting of the House of Delegates
Thursday, May 4, 1995

▼ ***Delegates/guests present***

A list of the delegates and guests present is on file in the Executive Office of Med Chi.

▼ ***Call to order***

The meeting was called to order at 1:15 p.m. by Allan D. Jensen, M.D., speaker of the House of Delegates. The meeting was held at the Inn and Conference Center, University of Maryland, College Park, Maryland.

▼ ***Invocation***

The invocation was delivered by Rev. Holly Ulmer.

▼ ***National Anthem***

The National Anthem was sung by Jamie Fox, a voice major at the University of Maryland.

▼ ***Credentials Committee report***

Stuart Brager, M.D., chairperson of the Credentials Committee, reported that a quorum was present.

▼ ***Approval of minutes***

The minutes of the January 28, 1995, House of Delegates meeting were approved as presented.

▼ ***Visiting dignitaries***

The speaker of the House recognized the dignitaries present, who included Carol A. Tavani, M.D., president-elect of the Medical Society of Delaware; Russell D. Evett, M.D., president of the Medical Society of Virginia, and his wife, Gail; and James D. Helsley, M.D., president-elect of the West Virginia Medical Society.

Lonnie Bristow, M.D., president-elect of the AMA, was introduced by the speaker. Dr. Bristow noted that Maryland provides inspiration to the rest of the country and has contributed much at the AMA level.

▼ ***Awards presentations***

The speaker called upon the president, Donald H. Dembo, M.D., to present the awards.

- **50-Year certificates**

  The following physicians were present to receive their 50-year certificates:

  Thomas Russell, M.D., Theodore Woodward, M.D., Daniel Ehrlich, M.D., and Charles Williams, M.D. Sixteen other physicians have earned their 50-year certificates, but were unable to attend.

- **American Medical Association Education and Research Foundation (AMA-ERF) checks**

  Elizabeth Linhardt, chairperson of Maryland's AMA-ERF, and Adriana Zarbin, immediate past president of the Med Chi Alliance, assisted the president in giving out the AMA-ERF checks to the three medical schools.

  - Roland Smoot, M.D., associate dean of student affairs at The Johns Hopkins University, accepted two checks. The school received more than $7,700 in unrestricted funds and a check for more than $17,000 in restricted funds for the Medical Student Assistance Program.
  - Ms. Ruth Bulger, vice president for scientific affairs of the Henry M. Jackson Foundation at the Uniformed Services University of the Health Sciences, accepted a check on behalf of the school.
  - Dr. Claudia Baquet, associate dean for policy and planning at the University of Maryland, accepted two checks for the University of Maryland medical school. The school received more than $16,000 in unrestricted funds for its excellence program and more than $17,800 in restricted funds for its student assistance program.

- **Wyeth-Ayerst Laboratories Physician Award**

  The Wyeth-Ayerst Laboratories Physician Award for Community Service is presented each year to a physician who has provided outstanding service to his or her community outside the field of medicine. Christopher Chelovitz from Wyeth-Ayerst joined the president to present the award to this year's winner, Howard Silby, M.D. Dr. Silby won the award for his sacrifices of time and energy for the benefit of the Olympic figure skaters since 1988. Dr. Silby served as their team leader, fund raiser, and physician. In addition, Dr. Silby had served as chairman of the Sports Medicine Committee of the U.S. Figure Skating Association for five years.

- **Medical Student Award for Excellence**

  Med Chi honored a medical student from each of the medical schools with an Award for Excellence in Orga-

nized Medicine. The speaker noted that each of the students receiving the award had excelled academically and had been actively involved in their community and medical student group. The following students received awards:

- Johns Hopkins University: Kelly Gebo.
- Uniformed Services University of the Health Sciences: Jeffrey W. Bitterman.
- University of Maryland: Lisa Smith

- **Committee Chairpersons Award of Recognition**
  The speaker presented awards to the following four chairpersons:
  - Robert J. Ancona, M.D., chairperson of the Immunizations and Infectious Diseases Subcommittee
  - Martin P. Wasserman, M.D., Council on Scientific Affairs
  - Howard L. Siegel, M.D., vice-chairperson of the Legislative Committee
  - Joseph Berkow, M.D., chairperson of the Managed Care and Third Party Liaison Committee

- **Recognition of Donald T. (Ted) Lewers, M.D.**
  Dr. Lewers was presented with a framed copy of the cover of the *Maryland Medical Journal* in honor of his years of continuous service in leadership positions to both Med Chi and the AMA, and for being the first AMA Trustee from Med Chi in 50 years.

- **Certificate for Scientific Activities**
  Henry Wagner, M.D., was presented with a Certificate of Appreciation for his work in organizing the annual meeting.

- **Malouf and Wagner Awards**
  The speaker noted that in 1991, both Dr. George Malouf, Sr., and Dr. Henry N. Wagner received national awards. Dr. Malouf received the AMA Benjamin Rush Award for outstanding community service and Dr. Wagner received the AMA Scientific Achievement Award. Both physicians donated the monetary portion of their award to Med Chi to be used as incentives for the youth of Maryland.

  The 1995 Malouf Community Service Award was presented to Jamal Weems, a junior at Northern High School in Baltimore City, for his outstanding community involvement.

  The 1995 Wagner Science Award was presented to Jeremy D. Collins, a Maryland high school student who has demonstrated excellence in science.

- **Other awards**
  Governor's Citations for Excellence were presented to Drs. Theodore E. and Celeste Woodward. Dr. Theodore Woodward was instrumental in creating a new generation of caring physicians as a professor at the University of Maryland School of Medicine and is world renowned in the area of infectious diseases. Dr. Celeste Woodward was a volunteer physician in the Far East and the Governor's Citation for Excellence was presented to her for her commitment to a community not defined by the borders of a country.

  The speaker announced that the winners of the 12th annual photo contest were John B. DeHoff, M.D., (first place) and Chris Papadopoulos, M.D., (second place). Eleven physicians submitted a total of 27 photos in the contest.

▼ *Emeritus members*

Carol W. Garvey, M.D., treasurer, asked that the reading of the list of members requesting emeritus membership be dispensed with since the list was mailed with the packet. The House approved dispensing with the reading of the list and approved emeritus membership for the names submitted.

▼ *Necrology report*

Paul A. Stagg, M.D., secretary, noted that the House had received the list of deceased members and asked that the name of Marion Carlyle Crenshaw, M.D., who died tragically after the list was finalized, be added. At Dr. Stagg's request, the House joined in a moment of silence in memory of deceased colleagues.

▼ *Memorial resolutions*

The secretary read the following two Memorial Resolutions:

a. Marion Carlyle Crenshaw, M.D.

RESOLVED, That the Medical and Chirurgical Faculty of Maryland mourns the loss of Marion Carlyle Crenshaw, M.D., an extraordinary physician and teacher and respected member and colleague; and be it

RESOLVED, That the members of the Medical and Chirurgical Faculty of Maryland extend their deepest sympathy to our colleague, Lillian R. Blackmon, M.D., Dr. Crenshaw's widow, and to their family; and be it

RESOLVED, That members of the Medical and Chirurgical Faculty are encouraged to send memorial contributions to the University of Maryland Foundation M. Carlyle Crenshaw Memorial Lectureship, Development Office, 22 S. Greene Street, Suite 120, Baltimore, MD 21201.

b. John R. Smith, M.D.

RESOLVED, That this resolution be included in the minutes of this meeting and a copy sent to Dr. Smith's wife, Rebecca, and his sons, Douglas Carter and Richard Ashby, in recognition of the high regard in which Dr. Smith was held by the physicians of Maryland.

▼ ***Speaker of the House of Delegates report***

The speaker noted that since the last annual meeting, at which time new bylaws were approved, much has been accomplished. He has met with the specialty society section and the resident section and a resident has been participating in Board of Trustees meetings. He participated in the Personnel Committee to determine a way to measure the effectiveness of the chief executive officer and others of the executive staff. He noted that an IPA had been approached with caution and there was much work still to be done.

The speaker said it had been a pleasure to represent the House on the Board of Trustees and noted that all of the trustees are loyal and base their decisions on what they think is best for Med Chi. Dr. Jensen thanked Louis C. Breschi, M.D., vice-speaker of the House, and all the delegates for their help and support during the year. Dr. Jensen thanked the staff members for their help.

▼ ***Personnel Committee report***

Paul A. Stagg, M.D., chairperson of the Personnel Committee, reported that the committee had completed its first annual evaluation of the CEO and made its final report, which was accepted by the Board of Trustees on April 20, 1995.

The committee was formed by the new bylaws passed in May 1994. Dr. Stagg noted the difficulty the committee had since Med Chi had not developed any measurable tool to rate the CEO, nor had a job description been written for the CEO. The evaluation form that was finally created by the Personnel Committee was based on recommendations from the Retreat Committee, with revisions to make the form as objective as possible. The form was reviewed by Angus Everton, Esq., for legal sufficiency and to assure that its use would be consistent with the CEO's contract. The proposed form was submitted to the CEO and he concurred with its use. The form consisted of five areas of performance, each including several criteria. Comments were solicited from several Med Chi leaders who were dependent upon the CEO for support, including the president, the treasurer, the chairperson of each council and the president of each component society. The speaker of the House was a member of the committee.

The final report was that the performance of the CEO during the past year had been satisfactory. The details of the rating were confidential and not made public. The CEO gave a written response in which he accepted the report. The CEO also met with the committee to review the report. The committee also found that the CEO had been operating in an environment which was not conducive to effective work. He had received conflicting instructions from different officers. Some Med Chi officers had dealt directly with outside parties without coordination. On April 20, the Board of Trustees accepted the final report of the evaluation and the committee's recommendations to formulate promptly specific objectives for the CEO next year and to define the work relationship and expectations of the CEO and the Board of Trustees.

Dr. Stagg concluded by thanking the members of the Personnel Committee for their efforts in developing a fair and useful evaluation: Drs. J. Ramsay Farah, Carol W. Garvey, Allan D. Jensen, and J. Richard Lilly.

▼ ***President's report***

Donald H. Dembo, M.D., Med Chi president, reported on Resolution 5-95, which directed Med Chi to request financial information from HMOs about health industry profits, which would be made public. Dr. Dembo noted that SB452, which addressed that subject, was sponsored by Maryland State Senator Paula Hollinger, but it failed in committee. The issues in Resolution 1-95, Bill of Rights for Managed Care and Panel Physicians, were incorporated into the Patient Access Act.

Regarding BlueCross BlueShield, Dr. Dembo noted that while its request for restructuring was denied, its request to establish a fee schedule based on RBRVS was approved by the insurance commissioner. Dr. Dembo noted that there have been meetings with BlueCross BlueShield, one moderated by state legislative leadership, and another by the secretary of the Department of Health and Mental Hygiene, and there has been agreement for further physician participation with them. The Board of Trustees instructed Med Chi staff to address specific issues with BlueCross BlueShield staff.

Dr. Dembo reported that the AMA Leadership Conference in Washington, D.C., offered opportunities to listen to the leadership of Congress address health care issues and update members on Washington's legislative issues and the AMA's patient access and noneconomic liability cap campaigns.

Med Chi had the opportunity to meet independently with U.S. Senator Barbara Mikulski to inform her of the importance of the $250,000 cap on noneconomic liability awards.

Dr. Dembo reported that Med Chi has an opportunity to develop a pilot program in third-phase clinical research with Quintiles. Quintiles is located in Research Triangle Park, North Carolina, and contracts with many pharmaceutical companies for their research needs.

▼ ***Chief executive officer's report***

Angelo J. Troisi, F.A.C.H.E., chief executive officer, noted that many projects had been completed for the members:

- Med Chi receives an average of 600 phone calls per day. These do not include the additional 100 calls daily to the Physician Rehabilitation Program.
- A new telephone service was installed, which created a savings of $10,000.
- For additional safety, awnings were placed over the rear entrance of the Faculty building and the entrance of the Coggins building.
- Eleven windows were replaced on the front of the Faculty building to enhance appearance and reduce heating and cooling costs.
- Because of Med Chi's need for expansion space, the Gunther building on Maryland Avenue was purchased. This adds 4,000 square feet for the Med Chi Agency and includes eight to ten offices.
- To provide for additional parking as mandated by the House of Delegates, Med Chi acquired the managerial use of the Greek Cathedral parking garage on Maryland Avenue, which will accommodate 90 cars and will be used mainly by the employees, freeing up the back parking lot for physicians.
- Med Chi is now able to use both floors of its Annapolis office building, since the Democratic Club no longer leases part of it.
- The legislative communications program identified key legislators on the patient access issue and succeeded in getting hundreds of letters from Maryland citizens requesting legislative support of Med Chi's patient access bill. The CEO felt that the grassroots effort was important in getting the bill passed, and it provided Med Chi's physicians with broad-based support of citizen-planners, physician spouses, physician office staff, and patients.
- Med Chi reached out to its members with its President's Regional Meetings in Eastern, Western, and Southern Maryland for discussion of Faculty issues and an exchange of ideas.
- More than 2,600 physicians participated in educational programs.
- More than 250 physicians received outreach assistance by members of the Physician Rehabilitation Program.
- In partnership with the Maryland Network Against Domestic Violence, Med Chi has had a very successful domestic violence education program for its members.

▼ ***Council reports***

(Council reports follow the minutes of the House of Delegates meetings. See page 629.)

▼ ***Maryland Physicians, Inc. update***

The speaker introduced Lawrence Pinkner, M.D., chairperson of the board. Dr. Pinkner noted that a permanent board of directors was formed in March and had held two meetings and a retreat since that time. He noted that Maryland is an advanced managed care state, but that the board is determined there has to be some type of statewide physician organization. There are more than 110 physician-centered IPA organizations already in existence. Maryland hospitals are under a regulatory system and Med Chi cannot negotiate with them.

The mission statement is to become an independent provider of quality and cost-effective medical care; to build a well-managed network of participating Maryland physicians which meets the needs of the community served and sets the standards of health care for the state.

Dr. Pinkner discussed the many different types of organizations they have considered. He noted that the board would like to form an integrated service network (ISN), getting contracts from the HMOs, insurance companies, Medicare, Medicaid, etc., and noted that the board would also like to network with the adjoining states. Dr. Pinkner states that whatever organization is formed, there are some rules it should always follow:

- 100% physician owned and controlled, including practice guidelines, quality of care, and utilization resources;
- contract with all qualified physicians and hospitals within the state;
- include all physician services if at all possible;
- willing to assume full-risk contract;
- membership open to all Med Chi members of MPI (the parent company);
- open to all existing groups that are now up and running.

Dr. Pinkner noted that it was important to keep fees low to enable everyone to join and that one day there would be a stock corporation to enable everyone to purchase stock. Physicians who have already sent in money when the initial letter went out from the interim board would have their money credited and will have no additional fees. Also, individuals who belong to other IPAs would not have an additional credentialing fee. A pre-determination date will be established and there will be a closing date. New providers and new physicians to Maryland will be able to join at the beginning of each calendar year.

Following this report, Albert Blumberg, M.D., Baltimore County, presented a resolution regarding this issue, to be considered as a late resolution:

> WHEREAS, This House of Delegates was electrified and stimulated by last year's report in the announcement of the creation of a Med Chi IPA, a physician-owned insurance company;
>
> WHEREAS, An IPA Committee has made the development of a physician-owned insurance company a secondary and lesser priority;
>
> WHEREAS, Many physicians believe the window of opportunity for the success of the new insurance company is closing; it is therefore
>
> RESOLVED, That this House of Delegates reaffirms its support for the development of its own insurance company in Maryland, and be it further
>
> RESOLVED, That the Board of Trustees instruct the IPA Committee as the IPA's principle stockholder to reprioritize and focus its efforts on the creation of a physician-owned insurance company in Maryland, and be it further
>
> RESOLVED, That the Board of Trustees instruct the IPA Committee to report back to the House of Delegates at the semiannual meeting in September concerning the status of the creation of a physician-owned insurance company in Maryland.

A motion was made and carried to have the resolution referred to the Reference Committee.

▼ ***Board of Physician Quality Assurance report***

Israel Weiner, M.D., chairperson of the Board of Physician Quality Assurance (BPQA), presented the annual report. Dr. Weiner noted that there were 109 prejudicial actions against 94 physicians and their physician licenses—actions that limit licensees in some way. There are 21,000 licensed Maryland physicians and of this number, 11,000 practice in Maryland. Of the 11,000, 9,000 see patients. Maryland is now, according to the Federation of Licensing Boards, the 12th ranking state and has improved its standing in the last several years from 49th. BPQA now has six full-time prosecutors to push the legal process along, and the emphasis is shifting from "malpractice" to "competence." Dr. Weiner noted that Med Chi's Peer Review Committee has done an excellent job, but its response is slower than he would like.

Dr. Weiner asked Med Chi to change its interpretation of the nomination process for members of the Board of Physician Quality Assurance. He noted that there are no physicians from the Eastern Shore, only two female physicians, no African-American physicians, and only one international medical graduate. He said that there is an obligation under the law that sitting members are automatically renominated, and Med Chi has taken the attitude that no other people can be nominated.

A question was asked about physicians being charged criminally when a medical mishap has occurred. Dr. Weiner noted that the BPQA's job is not to charge anyone criminally, and criminal prosecution depends upon law enforcement parties. Mr. Angus Everton, Esq., noted that criminal charges had been filed against a physician in Baltimore City arising out of a physical examination, that Med Chi had filed an amicus curiae brief on behalf of the physician, and that the issue is still pending before the Court of Appeals.

▼ ***Med Chi Alliance report***

The speaker introduced Adriana Zarbin, the immediate past-president of the Alliance. Mrs. Zarbin reported that she had attended Med Chi's presidential regional meetings. She also noted the Alliance's focus: membership, health projects, AMA-ERF, domestic violence, and health community projects, and explained what the Alliance has accomplished for each of these projects during the year.

▼ ***Maryland Medical Political Action Committee report***

Frederick Hatem, M.D., chairperson of the MMPAC board of directors, noted that he was concluding a two-year term as chairperson and at the beginning of his term he had set goals. He noted that the number one goal was to increase membership and that has been accomplished. He said Maryland was one of the top states for increased membership. He noted that Med Chi members in leadership positions should be members. Another goal was to increase cooperation between the statewide organization and component societies, and meetings have been held to reach

this goal. A financial audit was completed and found MMPAC to be financially sound.

Dr. Hatem noted that the purpose of MMPAC is to raise funds, educate membership, and let the legislature know of Med Chi's position on bills. He concluded by asking members to support Hilary T. O'Herlihy, M.D., the next chairperson of MMPAC.

▼ *Treasurer's report*

Carol W. Garvey, M.D., treasurer, reported that the financial statement had been distributed, and she briefly reviewed the information. The Med Chi audit for 1993 was completed and was generally acceptable. There were a few areas that needed improvement, and most had been improved in 1994.

She then reported that the former assistant controller had been indicted and his trial had been scheduled. She noted that this problem was identified by Glen Berger, the new controller, and that all the funds embezzled were expected to be recovered.

Dr. Blumberg, Baltimore County, asked about the problem of insurance covering the recovery of the embezzled funds, and whether it might be difficult for Med Chi to continue to have bond insurance. Dr. Garvey replied that Med Chi's first recourse is the offender, who is expected to make restitution. She also noted that the bank which the assistant controller was using to make these transactions erred in not having procedures in place to prevent these activities. Dr. Garvey said that the use of Med Chi's insurance was its last resort, and it is not anticipated to be needed.

Dr. Blumberg also asked whether Med Chi was operating on a deficit budget. The controller explained that it was a balanced budget, but that it appeared to be a deficit budget because part of the funds were capital expenditures.

▼ *Nominating Committee report*

The speaker noted that the Nominating Committee would not be reporting on the BPQA vacancies, but the names of the nominees for BPQA would appear on the ballot. In accordance with Maryland law, the names were submitted for consideration by all the licensed Maryland physicians. Three positions were to expire and the incumbents were Drs. Suresh Gupta, Charles Hobelmann, and Mary Newman. The names of the incumbents along with the names of all the physicians on the BPQA ballot would be submitted to the governor in the order of votes received.

The chairperson of the Nominating Committee, Joseph Snyder, M.D., presented the slate of nominees. The speaker explained that, after all the nominations were completed, each candidate would be allowed a total of two minutes for election speeches.

- Dr. Snyder announced that the nominee for president-elect was Alex Azar, M.D. There were no other nominations, and the nominations were closed.
- Dr. Snyder announced that the nominee for speaker of the House of Delegates was Allan D. Jensen, M.D. There were no other nominations, and the nominations were closed.
- Dr. Snyder announced that the nominee for the vice-speaker of the House of Delegates was Louis C. Breschi, M.D. There were no other nominations, and the nominations were closed.
- Dr. Snyder announced that the nominee for Baltimore City trustee was Joseph W. Zebley, M.D. Hiroshi Nakawaza, M.D., was nominated from the floor. There were no other nominations, and the nominations were closed.
- Dr. Snyder announced that the nominee for Baltimore County trustee was Thomas E. Allen, M.D. There were no other nominations, and the nominations were closed.
- Dr. Snyder announced that the nominee for Montgomery County trustee was Howard M. Silby, M.D. There were no other nominations, and the nominations were closed.
- Dr. Snyder announced that the nominee for Prince George's County trustee was Willie C. Blair, M.D. There were no other nominations and the nominations were closed.
- Dr. Snyder announced that the nominees for Eastern County Group trustee were L. Thomas Divillo, M.D., and Paul A. Stagg, M.D. The Speaker announced that Dr. Stagg had withdrawn his name as nominee for Eastern County Group trustee. There were no other nominations, and the nominations were closed.
- Dr. Snyder announced that the nominee for Southern County Group trustee was Hilary T. O'Herlihy, M.D. There were no other nominations, and the nominations were closed.
- Dr. Snyder announced that the nominees for Western County Group trustee were Wayne C. Spiggle, M.D., and J. Ramsay Farah, M.D. Dr. Farah stated that he wished to withdraw his name as a candidate for the position of Western County Group trustee. There were no other nominations, and the nominations were closed.
- Dr. Snyder announced that the nominee for trustee-at-large from any region was Carol W. Garvey, M.D. There were no other nominations, and the nominations were closed.
- Dr. Snyder announced that the nominees for the two positions of trustee-at-large from small components

were Federico G. Arthes, M.D., Joseph S. Fastow, M.D., and Allan T. Leffler, M.D. Paul A. Stagg, M.D., and J. Ramsay Farah, M.D., were nominated from the floor for the position of trustee-at-large. Drs. Joseph S. Fastow and Allan T. Leffler withdrew their names. There were no other nominations, and the nominations were closed.

- Dr. Snyder announced that the nominees for medical specialty section trustee were Joseph W. Berkow, M.D., J. Leonard Lichtenfeld, M.D., and Abdul Nayeem, M.D. There were no other nominations, and the nominations were closed.
- Dr. Snyder announced that the nominees for the four positions of AMA delegate were Alex Azar, M.D., Allan D. Jensen, M.D., George S. Malouf, Sr., M.D., and Henry N. Wagner, M.D. There were no other nominations, and the nominations were closed.
- Dr. Snyder announced that the nominees for the two positions of AMA alternate delegate were Louis C. Breschi, M.D., and Reynaldo Lee-Llacer, M.D. Michael Dobridge, M.D., was nominated from the floor. There were no other nominations, and the nominations were closed.
- Dr. Snyder announced that the nominees for resident alternate delegate to the AMA were Douglas Beall, M.D., Shannon Pryor, M.D., and Michael Sokol, M.D. There were no other nominations, and the nominations were closed.
- Dr. Snyder announced that the nominee for student alternate delegate to the AMA was Mary Guye. There were no other nominations, and the nominations were closed.
- Dr. Snyder announced that the nominee for the Finney Fund was Konstantinos G. Dristas, M.D. There were no other nominations, and the nominations were closed.

The speaker noted that there would be a ballot vote for all of the positions, unless there was only one candidate for an office. A motion was made and carried to dispense with the ballot for the uncontested positions. The speaker noted that elections for the contested positions would take place Saturday at the House of Delegates meeting beginning at 2 p.m.

Candidate speeches were given by the physicians running for contested positions, or by the individual noted after the candidate's name:

- Hiroshi Nakazawa, M.D.
- Joseph W. Zebley, M.D. (Willarda Edwards, M.D.)
- J. Ramsay Farah, M.D.
- Paul A. Stagg, M.D.
- Abdul Nayeem, M.D.
- J. Leonard Lichtenfeld, M.D.
- Louis C. Breschi, M.D.
- Michael Dobridge, M.D.
- Reynaldo Lee-Llacer, M.D.
- Douglas Beall, M.D.
- Shannon Pryor, M.D. (Donald H. Dembo, M.D.)
- Michael Sokol, M.D.

Dr. Blumberg asked whether all the candidates running for the positions would be able to serve the entire two-year period from January 1, 1996, to December 1997, especially Ms. Guye who may be out of medical school before her term ends. He also asked whether the student seat was a slotted seat or were she and the resident candidates running for the seat. Dr. Jensen noted that Ms. Guye's position is a slotted seat. Dr. Blumberg asked the House to challenge the ruling of the chair. Dr. Jensen asked if there was a challenge to the ruling that Ms. Guye is in the student slot. There was no challenge to the chair.

Dr. Snyder, chairperson of the Nominating Committee, stated that these problems had been considered, and that the student and resident AMA alternate delegates have served Med Chi well, even if not in long continuity. He noted that maybe in the future this matter should be considered as to whether these slots should be for one year. Dr. Jensen suggested that the reference committee process might be used.

▼ ***New business***

Alex Azar, M.D., Wicomico County, thanked the House for its confidence in electing him president-elect. He then asked the House to accept a late resolution from Wicomico County, which had been distributed to the House. The House approved the resolution to be heard by the Reference Committee.

▼ ***Announcements***

The speaker noted that the reference committees would meet from 9 a.m. until noon on Friday, May 5, 1995. He also announced that the next House of Delegates meeting would take place Saturday at 2 p.m. He reminded delegates that they would have to register and receive new delegate ribbons. He also announced that the Meet the Candidate Reception would be held tonight in the Exhibit Hall at 7 p.m. He then announced that a general meeting would be held immediately following adjournment of the House of Delegates meeting.

▼ ***Adjournment***

There being no further business, the meeting was adjourned at 4:50 p.m.

Respectfully submitted,
SECRETARY PAUL A. STAGG, M.D.

Minutes of the Meeting of the House of Delegates
Saturday, May 6, 1995

▼ ***Members/guests present***

A list of members and guests present at this meeting are on file in the Executive Office.

▼ ***Call to order***

The meeting was called to order at 2:10 p.m. by the speaker of the House of Delegates, Allan D. Jensen, M.D., at the Inn and Conference Center, University of Maryland, College Park, Maryland.

▼ ***Credentials Committee report***

Stuart Brager, M.D., chairperson of the Credentials Committee, reported that a quorum was present.

▼ ***Visiting dignitaries***

The speaker recognized the dignitaries present, who included Wayne Blackmon, M.D., and his wife, Joal Bennett-Blackmon, president of the District of Columbia Medical Society; Louis Keeler, M.D., president of the New Jersey Medical Society, and his wife, Margaret Mary; and Russell D. Evett, M.D., president of the Medical Society of Virginia, and his wife, Gail.

▼ ***Appointment of tellers***

Melvin Rapelyea, M.D., was appointed as head teller and Ben Oteyza, M.D., and Rafael Haciski, M.D., as tellers.

▼ ***Election of officers***

The speaker noted that, except for the president, president-elect, immediate past president, speaker, vice-speaker, and CEO, the bylaws require that trustees serve for three years. In addition, these terms must be arranged so that the terms of one third of the members expire each year. Since this was the first year for staggered terms on the board, the speaker recommended that the Credentials Committee choose the terms of office for the 11 members of the board affected by these requirements by picking the numbers out of a hat for each position. Four of the trustees will serve for three years; four will serve for two years, and three will serve for one year. There were no objections. The terms for the newly elected trustees were established as follows:

- Baltimore City—3 years
- Baltimore County—1 year
- Prince George's County—2 years
- Montgomery County—1 year
- Western County Group—3 years
- Eastern County Group—1 year
- Southern County Group—2 years
- Medical Specialty Section—2 years
- Trustee-at-Large from any County—2 years
- First Trustee-at-Large from Small Components—3 years
- Second Trustee-at-Large from Small Components—3 years

Joseph Snyder, M.D., chairperson of the Nominating Committee, reported that Dr. Arthes had withdrawn his name as a nominee for trustee-at-large from a small component. Thus, only two candidates remained for the two positions.

A question was raised regarding the BPQA nominations. Angelo J. Troisi, F.A.C.H.E., chief executive officer, explained that all the names of those nominated for the BPQA positions would be submitted to the governor, along with the number of votes received, and listed in the order of the number of votes received. Members asked whether the method used to obtain nominees allowed for nominees to place themselves on the list. Much discussion ensued about whether the House of Delegates should vote for BPQA nominees, whether they should postpone action until the next meeting, whether the matter should be referred to the Board of Trustees to decide about the voting, and whether the matter should be referred to the Bylaws Committee. The parliamentarian explained that Med Chi is obligated by law to submit the names of nominees to the governor, but the manner has been set by tradition. The CEO noted that Dr. Weiner was working with Med Chi to repeal the present law that opens the nominations to all Maryland licensed physicians. The speaker noted that this matter should be studied for next year.

A member noted that there were names on the list that some members did not want to endorse. A motion was made and carried to bring the matter to the Board of Trustees for action and to report back at the next meeting. The chief operating officer, Rose M. Matricciani, R.N., J.D., noted that if the House of Delegates did not vote today, it would have no input into the selection process. A motion was made to refrain from voting, then after discussion, was withdrawn. A motion was then made and carried to vote by last year's rules and refer to the Board of Trustees to decide for next year how the names should be submitted to the governor and whether submitting the names in a ranking position was proper.

▼ ***Initiatives from specialty societies***

Stuart Brager, M.D., president of the Specialty Society Section, reported that starting with the September 1994 semi-annual meeting, when the Specialty Society Section first met, elections were held and Dr. Brager was elected president and Paul McClelland, M.D., was elected secretary. Dr. Brager noted that there are 15 subspecialties attending the Specialty Society Section meetings and that there are 11 other subspecialties eligible to attend. One of the goals is to increase subspecialty attendance at both the section meetings and at House of Delegates meetings for those subspecialties that meet the criteria to have a delegate. There have been spirited discussions at the meetings on the BlueCross BlueShield restructuring problem. Other discussions have been universal credentialing procedures and the HMO impact on specialties and physician extenders. Dr. Brager noted the outstanding support received from Drs. Jensen and Breschi as well as from the Med Chi chief operating officer.

▼ ***Initiatives from component societies***

There were no initiatives from component societies. The speaker noted a lack of consistency in the times of year when delegates were elected by their societies. He suggested that a uniform term of office should be considered, with the delegates and alternate delegates remaining for a full term.

▼ ***Report of Reference Committee A***

Marianne Benkert, M.D., chairperson of Reference Committee A, presented the report. The committee members were William Bruther, M.D., Beverly Collins, M.D., Mark S. Seigel, M.D., and Eva M. Smorzaniuk, M.D.

a. *Resolution 13-95: Redefine DWI for Those Under 21 Years of Age*

The House of Delegates accepted the Reference Committee A recommendation to adopt the resolution with insertion and deletion so that it would read as follows:

RESOLVED, That the Medical and Chirurgical Faculty in consultation with the Office of the Attorney General and the Maryland State Police recommend to the Maryland General Assembly and support legislation which would redefine DWI for those under 21 years of age.

b. *Resolution 14-95: Laboratory Testing Fees*

The House of Delegates accepted the Reference Committee A recommendation not to adopt this resolution.

c. *Resolution 15-95: Laboratory Testing of HMO and Medicaid Patients*

The House of Delegates accepted the Reference Committee A recommendation that Resolution 15-95 be referred to the Board of Trustees for referral to the appropriate council for clarification, and to report back to the September 1995 meeting of the House of Delegates.

d. *Resolution 16-95: Accreditation Program of the Commission on Office Laboratory Accreditation*

The House of Delegates accepted the Reference Committee A recommendation that Resolution 16-95 not be adopted because a law has been passed regarding this issue, because this information has been published in the *Maryland Medical Journal*, and because the information has also been on Med Chi's 800 telephone line.

e. *Resolution 19-95: National Physician Health Insurance Company*

The House of Delegates accepted the Reference Committee A recommendation to adopt the resolution with deletion and insertion, and refer it to the Maryland AMA delegation for action and report back to the House of Delegates. The amended resolution reads as follows:

RESOLVED, That the AMA Board of Trustees be encouraged to study the feasibility of establishing a national physician health insurance company. The parameters such as profit versus nonprofit, and how it would tie into various state programs and other details, would be up to the Board for decision.

f. *Resolution 20-95: Med Chi IPA*

Before discussing the resolution, Reference Committee A requested that the House of Delegates be informed of the progress on the Med Chi IPA. The president then reported that two years ago the House of Delegates had voted to create a committee to look at Med Chi establishing an IPA. After extensive consultations, the Maryland Physician's Inc. (MPI) was established with first an interim board, and then early this year was incorporated and the Med Chi Board of Trustees elected a permanent board to include physicians from diversified geographic areas, gender, and specialties. Members of the MPI Board of Directors are:

- Lawrence D. Pinkner, M.D., chairperson
- Howard Silby, M.D., vice-chairperson
- Donald H. Dembo, M.D., secretary/treasurer
- Willarda V. Edwards, M.D.
- Michael S. Epstein, M.D.
- Allan D. Jensen, M.D.
- Edward W. Lampton Jr., M.D.

- Allan T. Leffler, II, M.D.
- J. Leonard Lichtenfeld, M.D.
- Frederick Miltenberger, M.D.
- Abdul Nayeem, M.D.
- Mark Seigel, M.D.
- Catherine Smoot-Haselnus, M.D.

Following the president's report, the House of Delegates approved the Reference Committee A recommendation that the resolution be approved with insertion and deletion to read as follows:

RESOLVED, That this House of Delegates reaffirm its support for the development of a physician-owned insurance company in Maryland, and be it further

RESOLVED, That Med Chi as MPI's principle stockholder strongly recommend to the board of MPI that the members continue to aggressively pursue its efforts on the creation of a physician-owned insurance company in Maryland, and be it further

RESOLVED, That the Board of Trustees instruct MPI to report back to the House of Delegates at the semiannual meeting in September concerning the status of the creation of a physician-owned insurance company in Maryland.

▼ ***Report of Reference Committee B***

Allan T. Leffler, M.D., chairperson of Reference Committee B, presented the report. The members were Amy Byer, M.D., Henry J. Farkas, M.D., and Catherine Smoot-Haselnus, M.D.

a. *Proposed Rules of Med Chi, Title 5—Procedures Before the House of Delegates*

Reference Committee B recommended that the House adopt in its entirety Title 5—Procedures Before the House of Delegates, with amendments. The House approved the Reference Committee B recommendation. The amendments approved are as follows:

5.2 *Resolutions*

Business shall be introduced into the House through the presentation of resolutions. Resolutions are required to be sponsored by (a) five members of the Faculty; (b) a component society of the Faculty; (c) a section; (d) a council; or (e) a committee of the Faculty. All resolutions shall be filed with the chief executive officer not later than 30 days prior to the next scheduled meeting of the House of Delegates, except that a component society *or section* may file a resolution no later than seven days prior to the first day of the meeting if the component *or section* has met to consider the resolution within the thirty-day period prior to the meeting, and except further that, by a two-thirds vote, the House may agree to consider any resolution without prior notice. Submission of resolutions to the Chief Executive Officer by personal delivery, first class mail or facsimile transmission are acceptable....

5.3.1 *Hearings*

Reference Committee hearings shall be held on the morning of each quarterly meeting of the House. At annual and semiannual meetings, Reference Committee hearings shall be held prior to the business session of the House, at a ~~time~~*time* set by the speaker, or in his or her absence, the vice-speaker. Hearings are open to members of the Faculty, guests, official observers, *and* interested outsiders ~~and the press~~. Any member of the Faculty is privileged to speak on the resolution or report under consideration. Nonmembers may, upon recognition by the chair, be permitted to speak, and the chair is privileged to call upon anyone attending the hearing if, in his or her opinion, the individual called upon may have information which would be helpful to the Reference Committee. Committee members may ask questions of any person speaking before the committee. The committee, through its chair, may establish its own rules on the presentation of testimony with respect to limitations of time, repetitive statements, and the like. The chair also has jurisdiction over such matters as photography, television filming, *the presence of the press,* and the introduction of recording devices. It is the responsibility of the committee to listen carefully and evaluate all opinions presented so that it may provide the voting body with carefully considered recommendations. The speaker, vice-speaker or chair of each Reference Committee may designate members of the staff of the Faculty, including the general counsel or legislative representatives, to attend hearings and executive sessions of each Reference Committee to provide appropriate technical assistance to the Reference Committees.

Note: 5.3.7 should be 5.3.6.

b. *Resolution 18-95: Policy on Med Chi Spokespersons*

Reference Committee B recommended the adoption of the resolution with insertion and deletions. Amendments were made to the Reference Committee B recom-

mendation, and approved by the House. The resolution as approved by the House reads as follows:

RESOLVED, That an available pool of individuals be developed to include the president, president-elect, members of the board of trustees, council chairpersons, committee chairpersons, and appropriate Faculty staff; and be it further

RESOLVED, That this pool of individuals receive regular training in media training; and be it further

RESOLVED, That the president is the official spokesperson for Med Chi regarding matters of policy. The president may designate other spokespersons when appropriate.

c. *Resolution 17-95: Nominating Committee*

Reference Committee B recommended that the House not adopt the resolution and that the issue be referred to the Bylaws Committee for drafting of a bylaws amendment to include specifics. A motion was made to add procedures for small component group nominations, then after discussion was withdrawn. The House amended the specific information that should be included in the bylaws amendment, then approved the amended recommendation. The Bylaws amendment is to include the following:

(1) submission of one name from each section noted in the bylaws (i.e., Baltimore City, Baltimore County, Montgomery County, Prince George's County, Western County Group, Eastern County Group, and Southern County Group) to the CEO by December 1st; and

(2) announcements of the members of the Nominating Committee at the January meeting of the House of Delegates.

Andrew Fridberg, M.D., chairperson of the Small Component Caucus, requested that the Med Chi staff be authorized to provide support for the regional county group nomination process.

▼ ***Election results***

Dr. Rapelyea, head teller, informed the House that the voting was invalid because there were two more ballots cast than registered delegates.

A delegate noted that some delegates had left and questioned whether another vote was necessary. The Parliamentarian noted that according to *Davis' Rules of Order*, if the total number of ballots exceed the number of people registered, another vote must be retaken.

After discussion, the tellers distributed new ballots. After the repeat vote, a run-off election was necessary for the position of resident AMA alternate delegate. The final results for the contested positions were:

- Baltimore City trustee: Joseph W. Zebley, M.D.
- Specialty Society trustee: J. Leonard Lichtenfeld, M.D.
- Two alternate delegates to the AMA: Louis C. Breschi, M.D., and Reynaldo Lee-Llacer, M.D.
- Resident alternate delegate to the AMA: Shannon Pryor, M.D.

▼ ***Oath of office***

The speaker asked the president, Donald H. Dembo, M.D., and the president-elect, J. Richard Lilly, M.D., and his wife, Elizabeth, to come forward. Dr. Dembo then administered the oath of office to the new president and presented the president's medallion and gavel to Dr. Lilly, which signified the change of the presidency. Dr. Lilly presented the past president's medallion to Dr. Dembo.

▼ ***President's speech***

Dr. Lilly expressed his appreciation to Dr. Dembo for leading the organization during the preceding year. He stated his goal is to bring unity and harmony to the house of medicine and urged that we speak in one voice. Dr. Lilly, while noting the diversity among Maryland physicians, pointed out that there is a bond that all physicians have—their dedication to their patients and profession. Dr. Lilly stated that without the input and support of physicians, no one could meaningfully address the future of health care, and reminded everyone that they must remain united. He concluded by stating that he was privileged to be Med Chi's spokesperson, honored to be their leader, and grateful for their trust.

▼ ***Immediate past president's speech***

Dr. Dembo noted that his presidency had been during a challenging time for Med Chi. He recalled many of the accomplishments which strengthened Med Chi's voice in medicine:

- Med Chi grew in membership;
- an antismoking campaign supported the passage of the most comprehensive regulations against smoking in the workplace;
- domestic violence was recognized as a major societal issue, and Med Chi developed a successful educational process for health care providers, which has become a national model;

- Med Chi interceded when BlueCross BlueShield applied to reorganize with a for-profit component, and negotiations are continuing;
- working with the Maryland legislature, Med Chi led the provider's coalition, with grass-roots support, to achieve passage of strong patient access legislation, resolution of the free-standing diagnostic center issue, reversal of the $5 nominal laboratory fee, an advanced uniform claim form, restructured health care arbitration system, and immunity from ordinary negligence for voluntary physicians.

Dr. Dembo also noted that some projects were not successful and that he had not realized all of his hopes. He stressed the importance of accepting differences of opinion and fully debating issues. Dr. Dembo shared his pleasure in meeting many people from Maryland and neighboring states. He thanked the staff and the council and committee chairpersons for their help. In closing, he recognized the support and understanding of his wife, Libby, and the "incredible opportunity" given him by the membership.

▼ *Announcements*

The speaker noted that the next House of Delegates meeting would be held July 15, 1995, that the deadline for resolutions for that meeting is May 26, and that any changes in the delegate roster must be received by May 16.

▼ *Adjournment*

There being no further business, the meeting was adjourned at 4:50 p.m.

Respectfully submitted,
SECRETARY PAUL A. STAGG, M.D.

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For The Physician Members of Med Chi

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◆ Council on Bylaws

The Bylaws Committee met before the summer meeting of the House of Delegates, and the 1994 semiannual meeting of Med Chi. This committee reviewed and reported its recommendations to the House on proposed bylaws changes which related to: limiting the terms of the speaker and vice speaker of the House; voting by the speaker and vice speaker of the House; voting by the AMA representative to the Board of Trustees; filling vacant Board positions; adopting rules and regulations; reporting of funds; submitting resolutions to the AMA; choosing a nominating committee; defining the purview of the Council on Bylaws; defining geographic distribution on the bylaws and rules committees; and defining House voting.

The Rules and Regulations Committee met to begin the work of writing rules for the House of Delegates and the Board of Trustees. A copy of the proposed rules was distributed to the members of the House for the 1995 annual meeting. Since these rules are extensive and this is the first time that rules have been written by the committee, the House approved a council recommendation to refer these rules to Reference Committee. The rules were heard by Reference Committee during the 1995 annual meeting, and approved by the House at its May 6, 1995 meeting.

GARY L. ROSENBERG, M.D.
Council Chairperson

Committees of the Council on Bylaws

- Bylaws Committee
- Rules and Regulations Committee

Lists of committee members for all committees begin on page 637.

◆ Council on Ethical and Judicial Affairs

The following activities have been conducted by the Council on Ethical and Judicial Affairs during the 1994-1995 year.

The Committee on Professional Ethics continued to review and approve corporate names, and approximately 38 corporate names were approved this year. The committee also received a number of requests for ethical opinions and was able to answer inquiries without writing new opinions. Another important initiative of the committee was reviewing the bill "Terminal Illness—Physician Aid in Dying." The committee did not take a position on this bill since the Board of Trustees had endorsed the AMA's position against physician-assisted suicide. The committee will be looking at sponsoring sessions on ethical issues at the upcoming Med Chi meetings.

The Peer Review Management Committee, which oversees all peer review activities of Med Chi and is chaired by Dr. Ronald Cohen, has had a busy year. Over 200 peer review reports have been completed and returned to the Board of Physician Quality Assurance since May 15, 1994, by the seven active peer review committees of Med Chi and the component medical societies. As has been the case in previous years, findings were split about 50-50 between findings that the respondent had met the standard of care and findings that he or she had not, indicating that the peer review committees continue to provide forthright and objective opinions.

Of those more than 200 peer review reports, better than 60% were completed by Med Chi's Peer Review Committee, under the leadership of its chair, Dr. James Karesh.

The Med Chi Committee on Drugs last year proposed that its primary function, the granting of permits to physicians to prescribe amphetamines, be abolished because this function had outlived its usefulness, and instead had become a bureaucratic interference in the ability of physicians to make appropriate decisions for the care of their patients. Therefore, Med Chi drafted legislation abolishing this function. We are pleased to report that this legislation was successful and that, as of July 1, 1995, physicians will no longer have to obtain a special permit to prescribe this medicine.

The Physician Rehabilitation Committee reviewed and approved of a one-hour CME presentation entitled, "The Scope of Physician Impairment" which has been offered to hospitals throughout Maryland. In 1994, over 2,300 physicians received outreach information or listened to a

presentation about the program. The committee also oversees articles for "Straight Forward," the physician rehabilitation department's newsletter which is mailed to every Maryland physician and to Maryland legislators. Another activity of the committee was cosponsoring the conference, "Alternatives in Healing the Total Person," which was held in November. Plans have already been started for the Sixth Annual Conference on Addiction which is tentatively scheduled for October 21, 1995.

The Mediation Committee reviewed two cases this year. Discussions with BPQA concerning monetary assistance for administrative duties is being explored.

MARIANNE BENKERT, M.D.
Council Chairperson

Committees of the Council on Ethical and Judicial Affairs

- Mediation Committee
- Peer Review Committee
- Peer Review Management Committee
- Physician Rehabilitation Committee
- Committee on Professional Ethics

Lists of committee members for all committees begin on page 637.

◆ COUNCIL ON LEGISLATION

The 1995 Maryland General Assembly ended its 90-day session at midnight on Monday, April 10, 1995. Just prior to the end of the session, the House/Senate Conference Committee report on the Patient Access Act (HB 724) was adopted, and the Patient Access Act was passed. The legislation has implementation dates ranging from October 1995 to March 1996, with the exception of the abolition of withholds.

The Patient Access Act contains the following provisions:

- Employers who offer a closed-panel HMO to their employees will now be required to also offer a point of service plan. HMOs will be required to offer point of service plans to Maryland employers.
- Insurance carriers will be required to review and respond to a provider's application for membership within certain time periods. Within 30 days, insurance carriers will have to either reject the provider or indicate an intent to further process an application for the purposes of obtaining necessary credentialing information. A final decision on an application is required within another 150 days.
- Carriers are not permitted to deny an application on the basis of gender, race, age, religion, national origin or disability protected categories; the number of appeals which the provider has filed contesting utilization review decisions; or the type or number of complaints or grievances the provider has filed with the carrier's internal review system.
- A provider may not be terminated from a provider panel or penalized for "advocating the interests of a patient," for filing utilization review appeals, or for using the carrier's internal review system.
- An insurance carrier's failure to adhere to these restrictions could result in a fine of up to $50,000 from the Maryland Insurance Administration.
- If a doctor is terminated from a panel without cause, his or her patients may continue to see the physician for a period of 90 days after the termination.
- Withholds are abolished as of July 1, 1996. The abolition of withholds also extends to bonuses which "deter the delivery of medically appropriate care to an enrollee." This is the first abolition of withholds in the United States and is considerably broader than the present Medicaid/Medicare law and regulations.
- Insurance carriers are required to establish an internal review system to resolve any grievances by providers. Failure to do so could result in a penalty or fine by the Maryland Insurance Administration.
- Insurance carriers are prohibited from discriminating in provider selection solely on the basis of licensure. In other words, a panel cannot limit applications to optometrists as opposed to ophthamologists, or psychologists as opposed to psychiatrists.
- The legislation also establishes that two studies be conducted. One study will be conducted by a four-person group to determine whether there is a need for

Maryland to require all health care practitioners to participate in Medicaid. This study will result in a report to the General Assembly on or before December 15, 1995. The second study, conducted by the Governor's Task Force on Community Health Networks, is to determine what further regulation is necessary to ensure that health care delivery networks remain responsive to their communities, are "broadly representative" of the health provider community and maintain necessary capitalization reserve requirements. This study will be reported to the Governor and the General Assembly by December 15, 1995.

The Maryland General Assembly also took action on a number of other bills that are significant to the medical community.

Health Care Reform Act of 1995—"Ambulatory Surgery." On the last day of the session, Senate Bill 639 was resolved by a six-person conference committee and passed by the legislature. This bill's final provisions establish

- the licensing of ambulatory surgery centers in compliance with Medicare standards;
- a certificate of need process for *future* ambulatory surgery centers with more than one room. One room "centers" would be completely exempt from the certificate of need requirements. A certificate of need for a second room could be obtained in an expedited approval process.
- that all facilities opened by June 30, 1995—including those planned facilities which received exemption letters by February 13, 1995, provided there has been a $25,000 commitment—are grandfathered under prior regulations.

The issues of hospital uncompensated care and graduate medical education expenses of the teaching hospitals will be studied by the Department of Fiscal Services, with a report expected in December 1995. The original proposal on these items was that the freestanding ambulatory surgery centers would be assessed to contribute to hospitals for uncompensated care and graduate medical education expenses.

Volunteer Providers and Physicians'—Immunity—Insurance Requirement. House bill 549, which repealed a requirment for volunteer health care providers and physicians at charitable organizations or the charitable organizations at which they work to carry a certain amount of insurance, was passed on the last day of the session. This was a Med Chi-supported initiative, and will be one of the few instances under Maryland law where a volunteer health care provider is immune from certain types of civil liability.

Diagnostic Testing/$5.00 Nominal Fee. The $5.00 limitation on the fee a physician could charge for obtaining and handling a specimen was repealed. This limitation was imposed in 1993 by House Bill 1359.

Uniform Forms. House Bill 961—which mandates that the insurance commissioner, in conjunction with representatives from the provider and payer community, develop a uniform laboratory form and consultation referral form—passed on the last day of session.

Health Care Arbitration System. The health care arbitration system was radically changed by the passage of House Bill 1049. This legislation provides that either party in arbitration before the Health Care Arbitration Office can elect to have the case go directly to the Circuit Court for trial. This means that the unnecessary delay, expense and duplication of trying a medical malpractice case first in the Health Care Arbitration Office and then again in the Circuit Court will be eliminated. However, the arbitration system can remain in place in situations where both parties believe it is beneficial to have the case tried by the Health Care Arbitration Office.

Other Bills of Interest. The final days of the 1995 session saw the passage of House Bill 438, Insect Sting Emergency Treatment Program, a bill supported by Med Chi, which allows epinephrine to be administered by nonphysicians in emergency bee sting situations. The bill provides that the Secretary of Health and Mental Hygiene will propose regulations and training rules for this program.

House Bill 1260, another Med Chi supported initiative, which repealed the prohibition on dispensing methamphetamines and amphetamines, also passed.

HILARY T. O'HERLIHY, M.D.
Council Chairperson

Committees of the Council on Legislation

- Legislative Committee

Lists of committee members for all committees begin on page 637.

◆ Council on Medical Affairs

During the 1994-1995 year, both the Committee on Young Physicians and the Women in Medicine Committee discussed ways to increase membership. The Committee on Young Physicians determined that it should begin by recruiting senior residents to become Med Chi members. The Committee also discussed forming a mentoring program for physicians who are opening their first practice. The program could provide insight, advice and referrals for businesses with which the mentors have had good business interactions.

In conjunction with *Physician's Practice Digest*, The Committee on Young Physicians sponsored a practice management session at the 1995 annual meeting. This session, entitled "Practice Management Strategies for Young Physicians," addressed practice start-up and operational issues.

As part of its efforts to increase membership, the Women in Medicine Committee sponsored two networking luncheons. Both luncheons were well attended and the committee received many ideas for future projects. The committee will continue to sponsor similar luncheons and events throughout the year.

To help promote women's health issues, the Women in Medicine Committee began planning a special issue of the *Maryland Medical Journal* which would focus on women in medicine and women's health issues. The committee developed a list of topics, and is currently in the process of recruiting authors for this issue. The committee also plans to sponsor a continuing medical education seminar during the 1995 semiannual meeting on a topic related to women's health.

Michael A. Berman, M.D.
Council Chairperson

Committees of the Council on Medical Affairs

- Women in Medicine Committee
- Committee on Young Physicians

Lists of committee members for all committees begin on page 637.

◆ Council on Medical Education

The Council on Medical Education encompasses four committees. Two committees of the Council on Medical Education, the Committee on Scientific Activity and the Committee on Continuing Medical Education Review, are closely involved with the direct provision of continuing medical education programs in Maryland. A third committee, the Committee on Specialist Identification, works with the Board of Physician Quality Assurance (BPQA) to review applications from physicians for specialist designation. And, finally, through the efforts of its editorial board, the *Maryland Medical Journal* provides information about a broad range of subjects to all Med Chi members on a monthly basis.

Med Chi is accredited by the Accreditation Council for Continuing Medical Education to perform two CME functions. One function is to sponsor AMA Category 1 CME activities. This is done through the efforts of the Committee on Scientific Activity.

Over the past twelve months, the Committee on Scientific Activity provided a variety of scientific presentations at the annual and semiannual meetings, regional meetings, at Med Chi, and at hospitals and other sites throughout the state. In addition to these Category 1 offerings, three AMA programs for physicians' office staff were presented at Med Chi.

Most CME activities are planned for specific Med Chi meetings, but, through educational grants, Med Chi has been fortunate to be able to offer two other major programs throughout the year at many different sites. Under a grant, Substance Abuse Education for the Primary Care Physician presentations were made at 16 sites, primarily hospitals. Under another grant, The Maryland Physicians' Campaign Against Family Violence presentations were made at 40 hospitals, health departments and medical societies. Over the course of the year, total physician attendance at Category 1 CME activities was 1,274, and total nurse attendance at all activities was 1,434.

The second CME function handled by Med Chi is to accredit intrastate sponsors of CME to serve the needs of specific organizations and hospitals. The Con-

tinuing Medical Education Review Committee, chaired by Dr. Abdul Nayeem, performs this function. The committee received a four-year reaccreditation from the Accreditation Council for Continuing Medical Education (CMERC) this past year. The CMERC works with 57 organizations and hospitals throughout Maryland, enabling physicians in every area of the state to attend excellent CME programs locally.

Before physicians can advertise that they specialize in a particular area, they must be board certified or have the approval of Med Chi and the Board of Physician Quality Assurance. Dr. Samuel D. Friedel chaired the Committee on Specialist Identification, which considered 323 applications for specific designations this past year. Of these applications, the committee recommended approval for 307, and denied 16.

During the past year, the *Maryland Medical Journal* has continued to publish original research, case studies, review articles, diagnostic and therapeutic updates, articles on medical history, as well as commentaries and editorials on numerous subjects of interest to Maryland physicians. At the same time, the journal's editor, Dr. John W. Buckley, M.D., has overseen the addition of several new, regular columns and features, including "Geriatrics for the Clinician," "Maryland Medicine in Review," "What Your Patients May Be Reading," and a summary page of items from other journals that is aptly entitled "Cite Seer."

During a trip to Chicago last February, Dr. Buckley met with George Lundberg, M.D., the editor of *JAMA*. Dr. Lundberg praised both the appearance and content of the *MMJ*, and spent over 90 minutes with Dr. Buckley discussing some of the strategies used at *JAMA* to enhance readership. Dr. Buckley expects to incorporate a number of Dr. Lundberg's ideas in future issues of the *MMJ*.

HENRY N. WAGNER, M.D.
Council Chairperson

Committees of the Council on Medical Education

- Committee on Continuing Medical Education Review
- *Maryland Medical Journal*
- Committee on Scientific Activity
- Committee on Specialist Identification

Lists of committee members for all committees begin on page 637.

◆ Council on Medical Services

The Council on Medical Services reports the following actions of its committees for the 1994-1995 year.

The HMO Quality and Practice Parameters Technical Advisory Committee (TAC) closely followed the activities of the state work group on HMO Quality and Practice Parameters and submitted recommendations regarding the HMO quality outcomes project and the development of enrollee and practitioner satisfaction surveys. J. Ramsay Farah, M.D., work group member and chair of the TAC, has been appointed chair of the Advisory Committee for the Practice Parameters Pilot Project. Dr. Farah, along with Sheldon Goldgeier, M.D., and Mark Seigel, M.D., will be members of the steering committee for the HMO practitioner satisfaction survey. Med Chi, in conjunction with the Delmarva Foundation for Health Care, Inc., submitted a proposal to the Health Care Access and Cost Commission to conduct the physician surveys; however, Med Chi and Delmarva were not awarded the contract.

The Computers in Medicine Committee has been active in looking into seminars which address the office use of computers. The committee will be pursuing CME credits for future seminars.

The Medical Care Database Development Technical Advisory Committee is preparing an interim retrospective database using information from insurers including 10 private payers, Medicare, and Medicaid. It will contain 100% of public and 55% of private claim volume from 1992 and 1993. The final prospective database of all encounters has been delayed and language to that effect was passed in HB1347. Major obstacles remain, and a confidentiality work group will be established this summer to address these issues. There is no requirement for electronic claims submission by July 1, 1995; several billing firms are using this date to sell products to physicians. Such solicitations should be reported to Med Chi.

The Managed Care and Third Party Liaison Committee spent much of its time addressing BlueCross BlueShield of Maryland's (BCBSM) proposal to convert from a non-profit entity to a for-profit operation. Committee chair Joseph Berkow, M.D., led the effort to address the problems associated with the for-profit proposal and the pro-

posal for a new RBRVU fee schedule. Med Chi president Dr. Dembo, along with Drs. Howard Siegel and J. Leonard Lichtenfeld and key staff members, testified at insurance commission hearings on both the proposal and the fee schedule. Med Chi was successful at stopping the for-profit proposal and the insurance commissioner's opinion reflected the concerns expressed by our panel. Med Chi was also successful at thwarting the efforts of BCBSM to place last-minute legislation in the Maryland legislature this year which would have allowed BCBSM to convert to a for-profit entity.

With regard to the fee schedule, the Maryland Insurance Administration (MIA) determined that BCBSM could implement an RBRVU fee schedule with eight (8) conversion factors because it would result in a savings to the consumer. In fact, because BCBSM used forward pricing, the consumer had already received the savings from the new schedule. The MIA reviewed the fee schedule only from the perspective of how it affects the consumer. Although BCBSM has reported a different percentage, physicians in various specialties have determined that their payments for important procedures in their practices will be cut from 30-47 percent. The committee will continue to follow this issue and to monitor the summer legislative work group that will be addressing BCBSM's proposal to become for-profit. The committee also focused on other managed care issues and recommended that a section of the *Maryland Medical Journal* be devoted to this subject. The committee also monitored the transition from BCBSM to TrailBlazer's with regard to the Maryland Medicare contract. Staff served as liaison to a transition consulting team and Dr. Berkow served as co-chair of the Carrier Advisory Committee. Another important activity for this committee was dealing with the overpayments by Pennsylvania Blue Shield. Med Chi and other state medical societies joined forces with the AMA and was successful in an unprecedented ruling against Medicare. Med Chi staff provided testimony at the hearing and assisted the AMA in obtaining a Maryland hearing officer.

JOSEPH FASTOW, M.D.
Council Chairperson

Committees of the Council on Medical Services

- Computers in Medicine Committee
- HMO Quality and Practice Parameters Technical Advisory Committee
- Managed Care and Third Party Liaison Committee
- Medical Care Database Development Technical Advisory Committee

Lists of committee members for all committees begin on page 637.

◆ Council on Planning and Development

The Council on Planning and Development reports the following for the AMA Delegation and the Public Relations Committee for the 1994-1995 year.

Throughout the year, the Maryland delegates to the AMA devoted much time and effort on behalf of the medical profession and the physicians of Maryland. Med Chi was represented well at both the AMA's 1994 annual and interim meetings.

At the 1994 annual meeting held in June, a Maryland physician, Michael A. Williams, M.D., was elected to the AMA's Council on Scientific Affairs. Alex Azar, M.D., was selected to serve as a member of the Reference Committee on Amendments to the Constitution and Bylaws.

During its annual meeting, the AMA House of Delegates considered a wide variety of issues including health system reform, patient protection and physician fairness with respect to managed care plans, public health initiatives, the definition of primary care, physicians workforce planning strategies, and violence in America. The House agenda contained 106 reports and 212 resolutions. The AMA reaffirmed its policies to protect patient choice; implement AMA policy to achieve universal access and coverage; and preserve and expand physicians' right to establish fair fees. The House also adopted a number of policy statements on physician workforce planning strategies, memories of childhood abuse, and violence in America.

At the AMA interim meeting which was held in December 1994, Carol W. Garvey, M.D., was selected to serve as

a member of the Reference Committee on Medical Education. The House considered 190 resolutions and 92 reports on topics affecting medical practices and public health. The House adopted several policies with respect to managed care, including policies which addressed financial incentives for physicians, post-operative services, pediatric subspecialties, board certification, resident training, and patient education. The House also approved a recommendation that the AMA's 1995 reform campaign focus on the Patient Protection Act, liability reform, insurance reform, medical savings accounts, regulatory reform, and physician network antitrust reform. With respect to public health, the House adopted resolutions encouraging the appropriate use of antibiotics and addressing the control of *E. coli* infection.

One of the Public Relations Committee's activities this year was to write and produce a flyer entitled "Choosing Your Health Care Plan." The flyer contains questions that people choosing a health care plan should consider. These fliers have been distributed to Med Chi members at all House of Delegates meetings.

The committee made recommendations to the Board of Trustees regarding Med Chi public relations initiatives, and the Board approved the committee's recommendations. These recommendations included supporting the efforts which Med Chi made regarding patient access legislation; developing a media/information packet about Med Chi which would be used for recruitment and media/information programs; developing position papers for Med Chi and providing media training for Med Chi spokespeople; and conducting a survey of physicians which will collect data about the amount of charitable care given by physicians. The results of this survey would be used to support legislative and public relations initiatives. The committee has begun collecting information about other uncompensated care surveys and will begin working on the survey instrument this summer.

In May, the committee submitted a resolution to the House of Delegates regarding the designation and training of Med Chi spokespersons to the media. This resolution was adopted as amended by the House at the annual meeting

JOHN C. GORDON, M.D.
Council Chairperson

Committees of the Council on Planning and Development

- AMA Delegation
- Public Relations Committee

Lists of committee members for all committees begin on page 637.

◆ Council on Scientific Affairs

The Council on Scientific Affairs was very active this previous year.

The Library and History Committee assisted library staff in preparing for two book sales, the proceeds of which will serve as the basis for a Marcia Noyes Fund for Library Technology.

The Committee on Medicine and the Performing Arts held a very successful conference on pain and the performer in late March. Eighty-five physicians, allied health professionals and performers attended the two-day conference at Med Chi.

The Public Health Committee continued to serve as the oversight committee for the activities conducted by the subcommittees on family violence; immunizations and infectious diseases; and infant, child, adolescent and maternal welfare. It also reviewed the initiatives undertaken by Med Chi with regard to the Robert Wood Johnson smokeless states grant. During its startup year, Med Chi has assisted the Smoke Free Maryland Coalition in getting organized, developing a speaker's bureau and curriculum, extending their efforts to community coalitions, and starting a newsletter. Med Chi also started a clearinghouse for publications related to smoking, was active in the Talbot County initiative against smoking, supported the MOSH regulations against smoking in the workplace, and supported FDA regulation of tobacco products. The committee also participated in reviewing a pro bono health services project for the state of Maryland and has suggested to the Public Relations Committee the concept of publicizing the pro bono work that physician members and component societies are currently doing.

The Baltimore Healthy Start Fetal and Infant Mortality Review Board met to review infant mortality cases in

order to provide recommendations to the Healthy Start program for systems changes.

The Immunizations and Infectious Diseases Subcommittee conducted two OSHA training seminars for physicians and their office staff during the last year. The committee also reviewed and supported the regulations for third-trimester syphilis testing; approved the state's immunization schedule; reviewed the vaccine-free program; reviewed the new recommendations for testing for TB in children; and discussed the issues related to the unique identifier number for reporting AIDS, HIV+ and low CD4+ counts.

The Infant, Child, Adolescent, and Maternal Welfare Subcommittee continued to review maternal mortality cases and infant mortality cases for the Healthy Start program. The committee also reviewed and made recommendations on the "Proposal for a Regionalized Perinatal System of Care in Maryland" and wrote resolutions on AZT treatment for HIV+ gravidas and 24-hour discharge for uncomplicated pregnancies which were approved by the House of Delegates. The committee also reviewed legislation pertaining to counseling HIV+ mothers and discharging mothers within 24 hours.

The Family Violence Task Force has trained over 4,000 health care providers across the state. The Marine and Navy Corps in Quantico, Virginia, is using Med Chi's physicians' manual to train health care providers. A Korean victims' brochure has been added to the English, African-American and Spanish brochures. Bus placards about the Maryland Physicians' Campaign Against Family Violence with domestic violence questions were placed in approximately 150 buses in the Baltimore area and Anne Arundel County. In addition to the training sessions held at hospitals, domestic violence seminars were presented to HMOs, senior citizen groups, and public health departments. To date, 22 out of 24 state health departments have received training. A nurses' manual on domestic violence has been finalized and will be going to print. Currently, the task force is finalizing its physicians' manual on child maltreatment.

The Emergency Medical Services Committee planned and implemented a dedicated issue for the *Maryland Medical Journal*, reviewed and made recommendations for the nursing home transfer form, and continued to monitor the State Emergency Medical Services Advisory Council activities.

The Addictions Committee became more active in reviewing and commenting upon legislative issues related to alcohol and addictive substances. In October 1994, the committee met with Dr. Peter Beilenson, Baltimore City Health Commissioner, to discuss the city's needles exchange program, treatment slots for addicts, and the new acupuncture program for addicted mothers. The committee also conducted a very successful conference in November entitled, "Alternatives in Healing the Total Person." In February, the committee met with Lieutenant Governor Kathleen Kennedy Townsend about addiction issues. The committee has also initiated sending a representative to the meetings of the Maryland Addiction & Recovery Coalition and assisted in supporting the effort to get the FDA to regulate tobacco products. Further activities of the committee were: preparing for a dedicated issue of the *Maryland Medical Journal*, and addressing the issue of inappropriate questions on licensure applications involving impairment.

The Bicentennial Ad Hoc Committee is preparing for the 1999 celebration and has designed a logo and a pin to signify the event. In addition, the committee is continuing to put together information for the *History of Medicine in Maryland* with the assistance of a medical historian.

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- Infant, Child, Adolescent, and Maternal Welfare Subcommittee
- Family Violence Task Force

Lists of committee members for all committees begin on page 637.

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Med Chi has already begun planning celebration activities for its bicentennial in 1999. If you have ideas or suggestions, please call Margaret Burri or Vivian Smith at 410-539-0872 or 1-800-492-1056.

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Communications	
Local advertising	$120,000
National advertising	22,000
Classified advertising	8,000
Reprints	1,500
Subscriptions	8,000
Non-subscription sales	1,200
Miscellaneous	100
Directory sales	7,000
Directory advertising	30,000
The Maryland Psychiatrist	4,600
Compendium	500
Model Hospital Medical Staff Bylaws	300
Annual meeting exhibits	30,000
Semiannual meeting exhibits	25,800
Travel revenue	1,500
Annual meeting ticket sales	7,500
Stupak radio paid from Members	20,000
Membership service - P.R. Campaign	200,000
TOTAL	$488,000
Computer services	
AMA profile	$300
Corporate/Undistributed	
ACEPS/MCEPS salary & benefits	$38,064
Education	
Statewide Substance Abuse Grant	$74,000
Continuing Medical Education	8,000
Med-Lantic Management Grant	268,000
Family Violence - from Cordel Fund	13,000
Healthy Start revenue	130,000
Robert Wood Johnson Grant	100,000
Family Violence Manuals	3,000
Family Violence Donations	2,000
OSHA Seminars	2,000
TOTAL	$600,000
Human Resources & Facility Management	
Building fund	$30,000
Finance and membership	
Membership dues	$1,525,450
Anticipated agency dividend & equity	300,000
Interest income	160,000
Investments--other funds	212,000
Insurance activities	170,000
Rental income	52,000
Collection service	28,000
Credit cards	1,500
Parking	700
Lists and labels	11,000
Subscription services	400
Dues collection fees	20,000
Specialist identification	3,000
Associated (ACEP\MSEPS)	12,000
TOTAL	$2,496,050
Library	
ICD9 code books	$500
Hospital library periodicals	350
Interlibrary loans	7,000
Literature searches	7,000
Music in medicine	200
Nonaffliated user registration	7,000
Salary and benefits funding	38,300
Physician book orders	100
Hospital book orders	600
Book & subscription funding	69,000
TOTAL	$130,050
Peer Review	
Licensure accessment	$106,296
Investment income	3,000
TOTAL	$109,296
Physicians Rehab	
Licensure accessment	$423,704
Investment income	3,000
Conference revenue	7,500
Focused professional education	13,000
Straight forward advertising	1,200
Unbilled BPQA income	65,000
TOTAL	$513,404
TOTAL REVENUES	**$4,405,164**
TOTAL EXPENSES	**$4,405,164**

Department Expenses

	Administration	Communications	Computer Services	Corporate	Education
Salary	$294,450	$155,675	$58,450	$52,850	$263,400
Salary incentive				20,000	
Benefits	73,002	33,626	14,725	47,430	52,153
Supplies	3,000	5,500	1,500	25,000	2,500
Equipment	2,000	6,500	20,000		
Maintenance			10,000	10,000	
Software		1,500	2,500		
Travel	14,925	1,650	500		2,000
Professional education	3,250	4,000	3,500		3,000
Tuition Reimbursement	966	805	322		1,288
Membership & certification	2,000	400	200		2,000
Books & Subscriptions	3,000	1,020	500		500
Postage and shipping	4,000	41,000	300	30,000	5,000
Printing and publishing		196,500	50		1,500
Photocopying	3,000			30,000	2,000
Contract services		31,808	3,000		25,000
Conferences & meetings	15,000			15,000	
AMA delegation travel				45,000	
AMA OSMAP				1,500	
AMA candidate support				25,000	
AMA S.E. delegation				3,500	
AMA delegation, misc.				2,000	
Leadership conference				5,500	
President's honorarium				30,000	
President's expense account				4,000	
Data processing			4,000		
Auditing					5,000
Awards		4,225			
Photo supplies		2,200			
Gifts and memorials		850			
Interlibrary loans					
Medlars					
Music in medicine					
Rent & indirect expense					
Auxiliary				1,000	
Public Relations		200,000			
Annual meeting		60,000			
Semiannual meeting		20,000			
Utilities				72,000	
Telephone	3,600			35,000	
Stupak Radio Program		20,000			
Insurance				55,000	
Parking				25,000	
Handbook		3,800			
Bylaws		3,000			
The Maryland Psychiatrist		4,000			
Directory		20,000			
Lobbyists & expense					
Direct grant expense					139,600
First aid supply room R.N.					
Annapolis office					
Miscellaneous					
Contingency fund				20,000	
TOTAL	$422,193	$818,059	$119,547	$554,780	$504,941

Department Expenses

Finance & Membership	Human Resources & Facility Mgmt.	Legal & Govt. Relations	Library	Peer Review	Physicians Rehab	TOTAL EXPENSES
$179,285	$157,750	$171,225	$135,325	$163,200	$204,600	$1,836,210
						20,000
38,727	39,753	33,903	28,013	35,251	44,194	440,777
1,000	11,500	2,000	4,000	3,000	5,000	64,000
3,800	1,000	5,000	1,700	3,400	4,500	47,900
	41,300		1,550	200	2,700	65,750
1,600						5,600
800	1,500	4,500	2,500	500	5,000	33,875
4,400	1,500	500	2,000	1,000	2,000	25,150
805	1,449	966	966	966	966	9,499
1,600	300	2,000	800	500	21,000	30,800
300	1,500	9,000	69,000	200	1,000	86,020
8,000	250	23,000	3,800	5,500	15,800	136,650
2,000			2,000	25,000	25,000	252,050
1,000			1,000	15,000	2,500	54,500
	27,000	1,600	4,000		3,500	95,908
		13,000		5,100	31,800	79,900
						45,000
						1,500
						25,000
						3,500
						2,000
						5,500
						30,000
						4,000
3,000						7,000
16,000				3,000	3,000	27,000
						4,225
						2,200
	1,500					2,350
			4,000			4,000
			4,000			4,000
			1,000			1,000
				13,600	27,000	40,600
						1,000
					8,000	208,000
						60,000
						20,000
						72,000
		8,000		4,800	4,000	55,400
						20,000
						55,000
				3,900	3,000	31,900
						3,800
						3,000
						4,000
						20,000
		162,800				162,800
						139,600
		1,000				1,000
		27,000				27,000
1,000		4,000			2,200	7,200
						20,000
$263,317	$286,302	$469,494	$265,654	$284,117	$416,760	$4,405,164

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  - Relapse Prevention
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  - Compulsive Eaters Group
- Interventions
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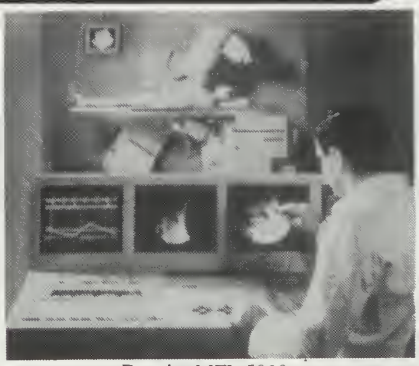
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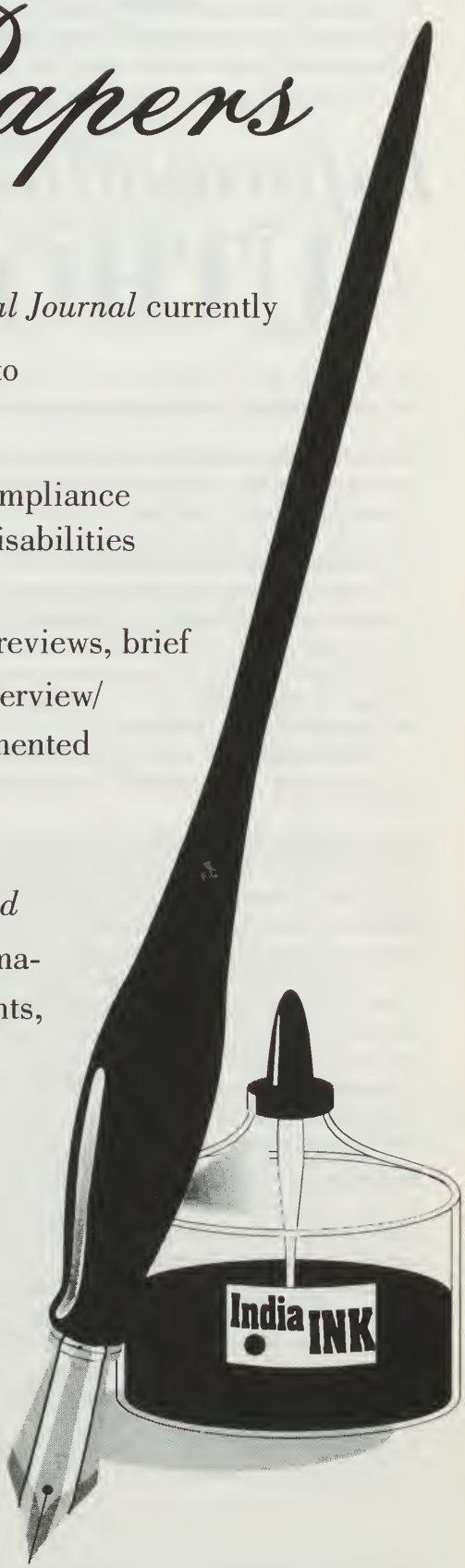
Call for Papers

The Editorial Board of the *Maryland Medical Journal* currently seeks original articles addressing topics related to

- Drug Interactions in the Elderly
- Strategies for Enhancing Therapeutic Compliance
- Assistive Technologies for People with Disabilities

Papers may be original research, literature reviews, brief reports, case histories accompanied by a brief overview/ summary of the relevant literature, or well-documented opinions about future trends.

All submissions should conform to *Maryland Medical Journal* requirements. For further information or to obtain a copy of submission requirements, contact Mary Ann Ayd, Managing Editor,
1211 Cathedral Street, Baltimore, MD 21201;
410-539-0872 or 1-800-492-1056;
FAX 410-547-0915.



The Maryland Medical Journal (MMJ) *is a monthly publication of the Medical and Chirurgical Faculty of Maryland. The journal's goals are educational and informative: the publishing of scientific articles (original research, case studies, and review articles) and other technical information, as well as editorials, letters, special articles (evaluations, position papers, reviews of nonscientific subjects), membership and legislative news, continuing medical education notices, and programs and policies of the faculty.*

Information for AUTHORS

- ***Letter of transmittal***—The letter of transmittal, which all authors must sign, should include the full names, degrees, titles, and affiliations of all authors, and the name, address, and phone number of the author to whom reprint requests and correspondence should be sent.

  The letter should include a statement to the effect that all authors have participated in the conception and design of the work and in the writing of the manuscript, and that they take public responsibility for it. The authors should attest to the validity and legitimacy of the data, and acknowledge that they have reviewed the final version of the manuscript and approve it for publication.

  In addition, the letter must include a paragraph that transfers copyright ownership to the *MMJ* in the event that the work is published.

- ***Manuscript preparation***—Manuscripts should be submitted to Editor, *MMJ*, 1211 Cathedral Street, Baltimore, MD 21201-5585. Manuscripts must be original material not previously published and not under consideration by another publication. An abstract of 100 to 300 words is required.

  All material, including references, tables, and legends, must be double-spaced. Pages should be numbered. (All abbreviations should be spelled out on first use.) The original manuscript plus one copy should be submitted on standard (8.5" x 11") bond paper. If at all possible, an IBM-compatible disk should be included, with the manuscript entered in a WordPerfect, Multimate, Wordstar, or ASCII format; the transmittal letter should identify the format used.

- ***References***—References are limited to those citations noted in the text. References should be numbered consecutively as they appear in the text and should be kept to a minimum (fewer than thirty-five). Personal communications and unpublished data are not acceptable. At a minimum, references should include names of all authors, complete title of the article cited, name of journal abbreviated according to *Index Medicus* (if abbreviation is not known, journal name should be spelled out fully), year of publication, volume number, and first and last page numbers. Sample references are as follows:

  1. Stevens MB. The clinical spectrum of SLE. Md Med J 1991; 10:875–85.
  2. Ropes MW. Characteristics, manifestations, and pathologic findings. In: Ropes MD, ed. Systemic Lupus Erythematosus. Cambridge, MA: Harvard University Press. 1976; 50–4.

- ***Tables***—Tables should be typed on separate sheets of paper, be numbered, and have a brief descriptive title. Data presented in tables should be self-explanatory and should supplement, not duplicate, the text; the Editor reserves the right to edit tables. Authors should be sure that statistics are consistent in both tables and text.

- ***Illustrations***—Illustrations include material that cannot be set in type. Photographic material must be submitted as high-contrast, glossy prints. Drawings and graphs must be done professionally in india ink on high-grade white drawing paper or be computer generated. Identification—including figure number, the title of manuscript, the name of corresponding author, and arrow indicating top—should be typed on a gummed label and affixed to the back of each illustration. Legends for illustrations should be typed on a separate page with numbers corresponding to those on the photographs or drawings. Recognizable photographs of patients are to be masked and should carry with them written permission for publication. Cost of printing color photographs must be borne by the author.

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  Accepted manuscripts become the permanent property of the *MMJ* and are subject to copy editing. (The *Chicago Manual of Style* and the unabridged *Random House Dictionary of the English Language* are used as style guides.) The corresponding author is sent a reprint order form and galley proofs. S(he) then has 48 hours in which to make minor changes and clear all corrections and changes with co-authors; if proofs are not returned by the specified date, they will be considered approved as typeset. ■

Checklist

- ☐ Original manuscript and one copy.
- ☐ IBM-compatable disk in WordPerfect, Multimate, Wordstar, or ASCII.
- ☐ Everything double-spaced.
- ☐ Letter of transmittal, signed by all authors, that includes release of copyright, statement of authorship responsibility, title and affiliation of all authors, and identification and phone number of corresponding author.
- ☐ Abstract of 100 to 300 words.
- ☐ Permission-to-borrow letters for any previously published illustrations or tables

The Johns Hopkins Medical Institutions

All courses at the Thomas B. Turner Building unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Medical Education, 720 Rutland Ave., Baltimore, MD 21205 (410-955-2959).

Fourth annual update on obstetric anesthesia and the first annual multidisciplinary pain medicine update, at the Stouffer Renaissance Harborplace Hotel, Baltimore, MD. Up to 13 Cat 1 AMA credits available. **Aug. 5–6**

Ninth annual core content of emergency medicine: a comprehensive review, at the Stouffer Renaissance Harborplace Hotel, Baltimore, MD. $850/physicians before June 30, after $900; $800/residents and fellows before June 30, after $900. **Aug. 14–20**

Practical issues in the diagnosis and treatment of glaucoma. Up to 7.5 Cat 1 AMA credits available. **Sept. 2**

Third annual airway management. Cat 1 AMA credits available. $700 physicians; $500/residents and allied health professionals; $350/one-day fee. **Sept. 8–10**

Johns Hopkins hepato-biliary update, at the Sheraton Fontainebleau Hotel, Ocean City, MD. Up to 11 Cat 1 AMA credits available. **Sept. 8–10**

Third annual progress in hematologic malignancies and bone marrow transplantation and pediatric hematology and oncology for the pediatrician, at the Stouffer Renaissance Harborplace Hotel, Baltimore, MD. 11.5 Cat 1 AMA credits available. $95/physicians and nurses. **Sept. 14**

Pediatrics for the practitioner: Update '95. Up to 14 Cat 1 AMA credits available. **Sept. 14–15**

24th Annual diagnostic ultrasound in obstetrics and gynecology and abdomen, at the Stouffer Renaissance Harborplace Hotel, Baltimore, MD. Up to 16.5 Cat 1 AMA credits available. **Sept. 15–17**

11th Birth conference: innovations in perinatal care, assessing benefits and risks, at the Hyatt Regency Baltimore Hotel, Baltimore, MD. Up to 13 Cat 1 AMA credits available. $300/physicians; $215/allied health professionals. **Oct. 7–8**

21st Annual topics in gastroenterology and liver disease. Up to 24 Cat 1 AMA credits available. Fee: $525/physicians; $275/residents, fellows; postmarked before 9/4/95, $495/physicians; $250/residents and fellows. **Oct. 11–13**

The second hands-on flexible sigmoidoscopy course. 7 Cat 1 AMA credits. $550/physicians; $400/residents, fellows. **Oct. 14**

37th Annual Emil Novak Memorial course: gynecology, gynecological pathology, endocrinology and high-risk obstetrics and second annual Richard W. Telinde lecture, at the Stouffer Renaissance Harborplace Hotel, Baltimore, MD. Up to 55.5 Cat 1 AMA credits available. **Oct. 14–19**

The second prevention of coronary heart disease, at the Sheraton Baltimore North Hotel, Baltimore, MD. Up to 8 Cat 1 AMA credits available. $1750/physicians; $130/residents, fellows, allied health professionals. **Oct. 18**

Comprehensive management of salivary gland neoplasms. Up to 10 Cat 1 AMA credits available. **Oct. 26–27**

The Johns Hopkins Medical Institutions (continued)

Topics in ambulatory medicine VII, at the Stouffer Renaissance Harborplace Hotel, Baltimore, MD. 18 Cat 1 AMA credits. $500/physicians; $300/residents, fellows, allied health professionals. **Nov. 15–17**

Advanced pediatric life support courses. 21 Cat 1 AMA credits available. $575. **Nov. 13–15, June 10–12**

Continuously throughout the year

Visiting preceptorship in pediatric critical care medicine. Ongoing five-day preceptorship by appointment. 40 Cat 1 AMA/PRA credits. $600.

The department of radiology and radiological sciences offers several courses in abdominal and obstetrical ultrasound. Info: P. Williams, 410-955-3169.

Visiting physicians. Offered throughout the year for experience in the lab and participation in read-in sessions; by appointment only. 40 Cat 1 AMA/PRA credits. $500.

Johns Hopkins medical grand rounds. Accredited audiovisual continuing education series of case discussions for clinicians; 30 topics per year in five bimonthly programs. Individual and group subscriptions. 40 Cat 1 AMA/PRA credits. Info: 410-955-3988.

Johns Hopkins sports medicine grand rounds. Accredited continuing education series of case discussions by a different presenter on the first Thursday of each month. Info: Carol Kelly, 410-383-0600.

University of Maryland School of Medicine

For each course, additional information may be obtained by contacting the Program of Continuing Education, University of Maryland School of Medicine, Room 14-011, BRB, 655 W. Baltimore St., Baltimore, MD 21201 (410-706-3956) or by calling the phone number listed after a specific program. FAX 410-706-3103.

1995 Advanced preoperative evaluation and planning for complex deformities, at the Pikesville Hilton Inn, Baltimore, MD. 25 Cat 1 AMA credits, 6 optional. $450. Info: Steven Kaniecki, 410-448-3394. **Sept. 16–19**

Women's health issues for the primary care provider, at the Sheraton Inn, Baltimore, MD. 7.5 Cat 1 AMA/AAFP credits. Info: Althea Pusateri, 410-706-3957. **Sept. 29**

Recent advances in mood disorders: controversy and consensus, at the Baltimore VAMC, Baltimore, MD, sponsored by the Department of Veteran Affairs and University of Maryland School of Medicine. 4 Cat 1 AMA credits. $35. Info: Susan Reed, 410-605-7000, ext. 6063. **Sept. 30**

7th Annual Maryland conference—AIDS: a challenge to primary care: science, practice, art, at the Baltimore Convention Center, Baltimore, MD. 9 Cat 1 AMA credits. $240. Info: Sylvia Scherr, 410-328-5759. **Oct. 5–7**

Treatment in epilepsy/Epilepsy Association of Maryland, at the Holiday Inn, Frederick, MD. Cat 1 AMA credits and fees TBA. Info: Cathy Bowers, 410-828-7700. **Nov. 3**

Endocrinology and metabolism update for the practicing physician—1995, at the Pier 5 Clarion Inn, Baltimore, MD. 10 Cat 1 AMA credits. $185. Info: John Wilber, M.D., Connie Ball, 410-328-2515. **Nov. 3–4**

Univerisity of Maryland School of Medicine (continued)

Self-Directed CME Activities

Optimal dosing in chemotherapy: adoptive control with carboplatin, video tape, monograph and test. Expires March 1996, 3 Cat 1 AMA credits. Info: 212-924-3044.

U.S. medical costs and values: primary prevention versus end stage treatment, monograph and test. Expires Aug. 1996, 2 Cat 2 AMA credits. Info: 908-281-3772.

Lipid management for coronary heart disease: a proven hypothesis, audio tape and test. Expires Aug. 1996. 1 Cat 2 AMA credit. Info: 609-497-9743.

Continuously throughout the year

Academic rounds and conference, each academic department within the school of medicine has a series of lectures and/or seminars available to physicians. Cat 1 AMA credits available. Info: 410-706-3956.

Miscellaneous meetings

1995 Risk management program: suit survival/lessons in risk management, sponsored by Medical Mutual Liability Insurance Society of MD. Med Mutual members who attend will receive a 5% discount on 1996 renewal premium. 2 Cat 1 AMA credits. $40. Info: Toni Davis or Natalie Poole, 410-785-0050, or 1-800-492-0193.

Ramada Inn, Hagerstown	**Aug. 3**
Kent & Queen Anne's Hosp, Chestertown	**Aug. 8**
Medical Mutual, Hunt Valley	**Aug. 9**
Colony South Hotel, Clinton	**Aug. 10**
Med Chi, Baltimore	**Aug. 15**
Shady Grove Advent. Hosp., Rockville	**Aug. 22**
Liberty Medical Center, Baltimore	**Aug. 24**
Medical Mutual, Hunt Valley	**Aug. 29**
Washington Advent. Hosp., Takoma Park	**Aug. 31**
Anne Arundel Med. Ctr., Annapolis	**Sept. 7**
Med Chi Semi-annual Meeting, Ocean City	**Sept. 9**
Medical Mutual, Hunt Valley	**Sept. 11**
Harford Memorial, Havre de Grace	**Sept. 12**
Cambridge Yacht Club, Cambridge	**Sept. 13**
Doctors Community Hospital, Lanham	**Sept. 14**
Medical Mutual, Hunt Valley	**Sept. 18**
Holy Cross Hospital, Silver Spring	**Sept. 19**
Frederick Memorial Hospital, Frederick	**Sept. 21**

Miscellaneous Meetings (continued)

Med Chi's 1995 Semiannual meeting: Working together—primary care for specialists; specialty care for primary care physicians, at the Princess Royale Oceanfront Hotel and Conference Center, Ocean City, MD. Up to 16 Cat 1 AMA credits available. No fee for members. Info: 410-539-0872, or in MD 800-492-1056. **Sept. 8–10**

Diabetic retinopathy: a comprehensive review & update, sponsored by the Retina Institute of Maryland at the Stouffer Harborplace Hotel, Baltimore, MD. 7.5 Cat 1 AMA credits. $250/physicians; $100/other. Info: 410-337-4500. **Sept. 15**

6th Biannual gastroenterology board review course, sponsored by the George Washington University Medical Center, at the Grand Hyatt, Washington, DC. Fee and credits TBA. **Oct. 7–11**

Medical oncology board review course, sponsored by the George Washington University Medical Center, at the Ritz-Carlton Pentagon City, Arlington, VA. Fee and credits TBA. **Oct. 8–12**

New techniques and concepts in cardiology, sponsored by the American College of Cardiology in Washington, DC. 16.5 Cat 1 AMA credits available. Info: 800-257-4739. **Oct. 19–21**

Mental health of women throughout the life span conference, at Sheppard Pratt Conference Center, Baltimore, MD. 6 Cat 1 AMA/PRA credits. Fee: TBA. Info: 410-938-4598. **Oct. 21**

Palliative care and the hospice concept, at GBMC in Baltimore, MD. 4 Cat 1 AMA credits. $50/physicians; $25/residents. Info: Ann Harris, 410-828-3670. **Oct. 28**

Care of the asthmatic patient: a multidisciplinary approach, at GBMC in Baltimore, MD. 7 Cat 1 AMA credits. $40/physicians and residents. Info: Ann Harris, 410-282-3670. **Nov. 1**

Pediatric ophthalmology: an update for pediatricians and family practitioners, at the GBMC Conference Center, Baltimore, MD. 4 Cat 1 AMA credits. Info: Ann Harris, 410-828-3670. **Nov. 4**

Twelfth annual clinical update in pulmonary medicine CME course and luncheon, at the Trump Regency Hotel in Atlantic City, NJ, sponsored by the department of pulmonary medicine, Deborah Heart and Lung Center. CME TBA. Info: 201-385-8080. **Nov. 19**

Continuously throughout the year

Fluorescein angiography conference, sponsored by the Retina Center, Saint Joseph Hospital, Baltimore, MD, first and third Mondays of each month; 8:00–9:00 am. Fee: none. Info: R. Classon, 410-337-4500.

Sinai Hosptial of Baltimore medical grand rounds, in the Zamoiski Auditorium on Thursdays, 9:00 - 10:00 a.m. Info: 410-578-5528.

Medical management of the injured brain	**Aug. 3**
Pulmonary hypertension	**Sept. 7**
Sickle cell disease: Recent advances in therapy	**Sept. 14**
First step choice of antihypertensive therapy to prevent coronary heart disease and renal insufficiency	**Sept. 21**
Resuscitation of patients with circulatory shock	**Sept. 28**
Adult immunization	**Oct. 5**
Chronic fatigue syndrome: fact or fiction	**Oct. 12**
Glaucoma: facts and fancies	**Oct. 19**

Miscellaneous Meetings (continued)

Leukotrienes in asthma	Oct. 26
Treating seizures in the decade of the brain	Nov. 2
Diabetic retinopathy	Nov. 9
AIDS: the state of the syndrome	Nov. 19
Acute myocardial infarction	Nov. 30
The renin-angiotensin system	Dec. 7
Community-acquired pneumonias	Dec. 14
Medical interviewing and the doctor-patient relationship in the managed care era	Dec. 21

PHYSICIAN'S RECOGNITION AWARD

During May 1995, the physicians listed below received the American Medical Association (AMA) Physician's Recognition Award. Established in 1968, the award's purpose is to encourage physician participation in continuing medical education and to recognize those physicians who have voluntarily completed programs of continuing medical education.

Richard J. Bass, M.D.
Robert D. Brodell, M.D.
Theresa A. Buck, M.D.
L. Thomas Divilio, M.D.
Stephen Epstein, M.D.
Habibollah Farhoudi, M.D.
David B. Glasser, M.D.
Barbara Highman, M.D.
Houston E. Holmes, M.D.
Herbert L. Kotz, M.D.
Philip London, M.D.
Mollyann G. March, M.D.
Martha J. Matjasko, M.D.
Sivarama K. Nandipati, M.D.
Frederick N. Pearson, M.D.
Helmy Abdul F. Qurtom, M.D.
Stephen C. Schimpff, M.D.
Michael G. Seremetis, M.D.
Hollis Seunarine, M.D.
Kenneth G. Torrington, M.D.
Hugh H. Trout, M.D.
Paul C. Turkeltaub, M.D.
Timothy J. Whalen, M.D.
Nieves M. Zaldivar, M.D.
Gino F. Zarbin, M.D.

Call For Papers

Uncertain Times: Preventing Illness, Promoting Wellness

1996 International Conference on Physician Health

February 8-10
Chandler, Arizona

Authors are invited to submit abstracts for consideration as part of the 1996 International Conference on Physician Health, which is sponsored by the American Medical Association, the Canadian Medical Association, the Federation of State Medical Boards, and the Federation of Licensing Authorities of Canada.

Presentations dealing with any aspect of physician health, including issues of well-being, impairment, disability, treatment, and education are welcome. Of particular interest are:

- Coping with changing economic or practice circumstances
- Stress and physician health
- Epidemiologic data
- The effects of violence directed at physicians
- Violence occurring within physicians' families
- Patient exploitation
- Mental illness, including substance abuse
- Physical illness and disability
- Special populations
- Comparative data across states or countries
- Physician well-being and family functioning
- Updates on clinical areas (depression, pharmacotherapy, etc.)

Three types of presentations are welcome:

- Poster presentations: written presentations of data-based research
- Paper sessions: Oral presentations of scientific, data-based findings on issues of physician health. Paper presentations will be grouped into related panels, with individual papers presented in 20 minute time slots
- Workshops: Training or instructional presentations designed to improve the skills and knowledge of persons working in the physician health field

Abstracts for all presentations must be submitted on the abstract submission form which is available from: American Medical Association, Physician Health Program, Attn. E. Tejcek, 515 North State Street, Chicago, IL 60610.

All presenters must register for the conference and will pay the AMA member rate. Presenters will be responsible for their own expenses.

Deadline for submission is October 2, 1995

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EPIDEMIOLOGY AND DISEASE CONTROL PROGRAM

201 West Preston Street, Baltimore, Maryland 21201 (410) 225-6700

August, 1995

Selected Communicable Diseases in Maryland in 1994 (Continued from July, 1995)

HAEMOPHILUS INFLUENZAE DISEASE (80)

1.6/100,000 (U.S. 0.4/100,000)

The 80 cases of invasive *H. influenzae* disease are an adjustment to the 87 cases reported in Table 1 (see July 1995 issue). The trend for all serotypes of invasive *Haemophilus influenzae* disease from 1985 to 1994 is shown in Figure 2. Ongoing active surveillance for invasive *H. influenzae* disease in hospitals and medical laboratories began in November 1991. This includes all serotypes of *H. influenzae*, not only serotype b. In 1994, the method of reporting changed from all cases by **onset** year to all cases **reported** in 1994. Due to this modification, there are 24 cases with onset in 1993 and included last year that are duplicated in the 1994 case count.

As in 1993, over 50% of the cases in 1994 were in the Baltimore metropolitan region. The Prince George's and Montgomery metropolitan area accounted for 26% of the cases. The highest incidence rates per 100,000 population were observed in Queen Anne's (5.5), Kent (5.4), Caroline (3.5), and Calvert (4.8) counties. The incidence in Baltimore City decreased from 2.2 in 1993 to 2.1 in 1994.

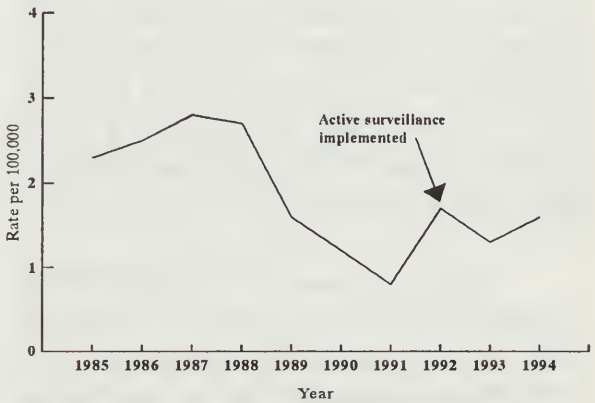


Fig 2. Haemophilus influenzae invasive disease. Incidence in Maryland, 1985-1994.

The incidence rate per 100,000 population was 1.5 for males and 1.7 for females. Rates for whites was 1.4 and for non-whites the rate was 2.1. There were no known cases among the Hispanic population for 1994. The case fatality rate for known outcomes in 1994 was 14.7%.

Ages ranged from one day old to 98 years (median 45 years). The number of cases by age categories for 1987 to 1994 are shown in Figure 3. Cases in children of immunization age continue to decrease. Only 9 cases of invasive *H. influenzae* disease were reported in 1994 among children 2 months - 4 years of age (none were type b). Seventy-four percent of the cases in 1994 were in the age category 20 years of age or older.

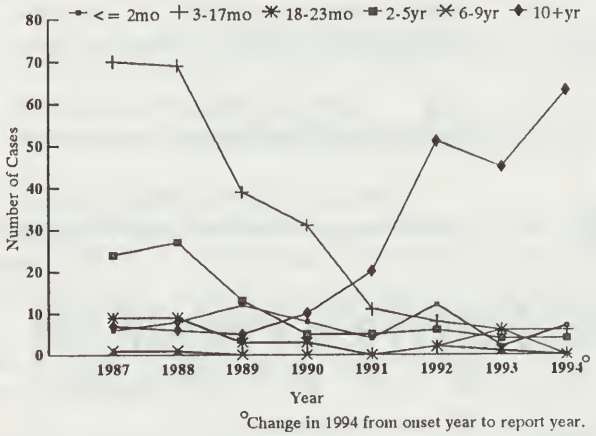


Fig 3. Haemophilus influenzae disease. Cases reported by age group, Maryland, 1987-1994.

Data on the serotypes of *H. influenzae* isolates were available for 46 (58%) cases. Serotype b was found for 20 (43%) cases, 5 (11%) cases were type a, 1 (2%) case was type c, 2 (4%) cases were type e, 8 (17%) cases were found to be type f, and 10 (22%) cases were non-typeable.

Of the 20 cases of *H. influenzae* type b disease (Hib), only one case, a 12 month old child, was eligible for Hib vaccine. One case of Hib disease occurred in a five year old girl who had been vaccinated against Hib. There were two cases of Hib disease in neonates (one day olds) and 16 children over 10 years of age and adults.

Infections caused by *H. influenzae* were bacteremia (46 cases, 58%), pneumonia (17 cases, 21%), meningitis (4 cases, 5%), cellulitis (1 case, 1%), arthritis (2 cases, 3%), and 10 cases (13%) had other infections not described.

Antibiotic susceptibility testing of 33 *H. influenzae* isolates revealed that 14 (45%) of the 31 isolates tested were resistant to ampicillin, and 7 (24%) isolates of 29 tested were resistant to chloramphenicol. The percentage of ampicillin resistant isolates in 1993 was 33%, and 48% in 1992.

HEPATITIS A (198)
4.0/100,000 (U.S. 9.0/100,000)

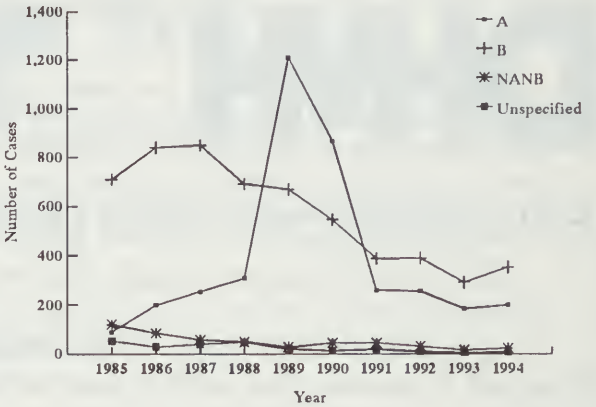


Fig 4. Hepatitis (A, B, NANB, and Unspecified), Cases reported, Maryland, 1985-1994.

The number of cases by jurisdiction is shown in Table 1 (see July 1995 issue). The incidence rate in 1994 increased slightly from the rate in 1993 (3.7/100,000). The trend in reported cases from 1985 to 1994 is illustrated in Figure 4. In 1994, 56% of all cases in Maryland were reported from Baltimore City and the surrounding five counties (Anne Arundel, Baltimore, Carroll, Harford, and Howard). The highest rate per 100,000 population was noted in Wicomico County (20.4) followed by Talbot (15.6) and Carroll (8.1).

The ratio of male to female cases was 1.4:1. The case ratio of whites to non-whites was 3.6 to 1; the race of 26 (13.1%) was unspecified. The rate in whites was 3.8/100,000 and the rate in non-whites was 2.5/100,000. White males had the highest rate per 100,000 population (4.5), followed by non-white males (3.3) and white females (3.2). Age and sex- specific rates are presented in Figure 5. In males the highest incidence rates occurred in the 20-29 year (9.4/100,000) and 30-39 year (6.6/100,000) age groups. In women the highest rates were reported among those 15-19 years (4.8/100,000) and 5-9 years (4.4/100,000).

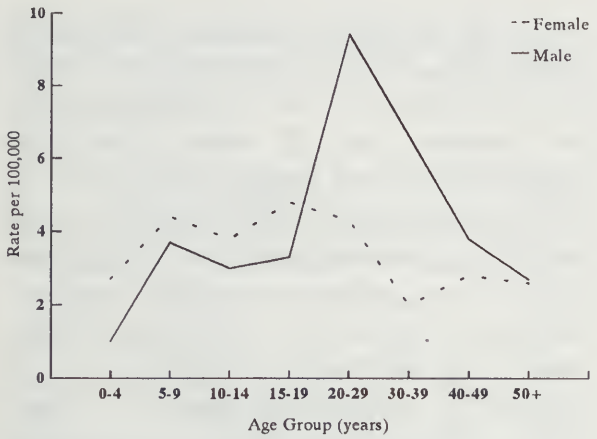


Fig 5. Hepatitis A. Incidence by age group and sex. Maryland, 1994.

Occupations or settings with increased risk of transmitting hepatitis A to the public include food handlers, health care providers, and those involved in the care of young children or the elderly. Of 136 persons reporting an occupation or setting, 10 reported high risk situations: 6 food handlers and 3 health care providers.

Among the 127 (64%) persons that completed a surveillance questionnaire that asked about risk factors for acquiring hepatitis A, 48 reported a single risk factor, and an additional 10 reported multiple risk factors. Risk factors reported included: travel outside the U.S. or Canada (29), contact to a confirmed or suspected case of hepatitis A (23), consumption of raw shellfish (8), attendance or employment at a children's day care center (5), household contact to a day care child or employee (3), suspicion of being part of a common source outbreak (3), and injection of street drugs (3).

HEPATITIS B (351)
7.0/100,000 (U.S. 4.4/100,000)

The 351 cases of acute hepatitis B reported here is an adjustment to the 354 cases reported in Table 1 (see July 1995 issue); cases by jurisdiction should be one for Frederick County and none for Talbot County. The declining trend in the number of cases reported since 1988 has been reversed with a slight increase in reported cases over 1993 (288) and is accompanied by an increase over the 1993 incidence rate (5.9).See Figure 4. Baltimore City reported 30% of all cases in the State, for a rate of 15.1 per 100,000 population. The highest incidence was noted in Somerset County (21.1/100,000).

The ratio of male to female cases was 1.5:1. The incidence rate per 100,0000 population was 8.5 in males and 5.5 in females. With race known for 82% of cases, the rate per 100,000 population in non-whites (10.8) was 3 times higher than the rate in whites (3.6). The incidence rates per 100,000 population by age group and sex is presented in Figure 6. The highest rates for both males and females were observed in the 20-29 years age group.

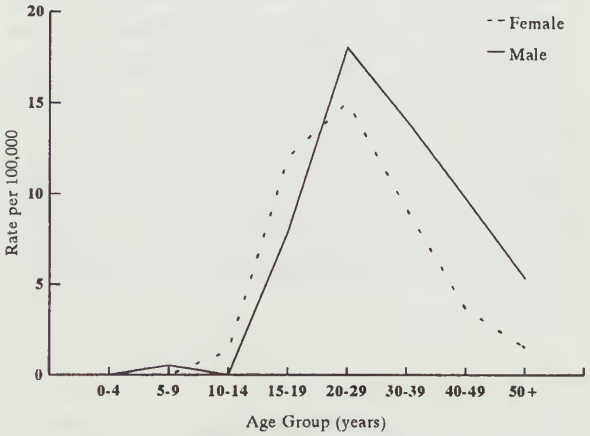


Fig 6. Hepatitis B. Incidence by age group and sex, Maryland, 1993.

Of the 83 adults with known occupation (excluding students, unemployed, unknown), only 1 was a health care provider with direct patient contact.

Information on exposures with potential risks for hepatitis B transmission during the 6 months prior to onset of illness was available for 212 (60%) of the cases.

Fifty-seven reported a single risk factor and 22 reported multiple risk factors. The most common risk factors reported included multiple sexual partners (26), use of needles for injection of street drugs (21), contact with a confirmed or suspected cases of hepatitis B or non-A/non-B hepatitis (13), dental work or oral surgery (13), and homosexual or bisexual preference (9).

LEGIONELLOSIS (82)
1.6/100,000 (U.S. 0.6/100,000)

The reported cases of legionellosis in 1994 increased by 58% from the cases in 1993 (52). The number of cases by jurisdiction is shown in Table 1 (see July 1995 issue). Almost a third (30%) of all cases occurred in Baltimore County. Carroll County (9 cases) had the highest rate (6.6/100,000) in the state.

The male to female ratio was 1.1:1.0. The incidence per 100,000 population in females (1.5) was slightly lower than the rate in males (1.7). The ratio of whites to non-whites was 2.0:1.0; the race of 10 cases was unknown. Ages ranged from 16 to 100 years (median 63 years); the age of 1 person was unknown. The incidence per 100,000 population by age group and sex is shown in Figure 7.

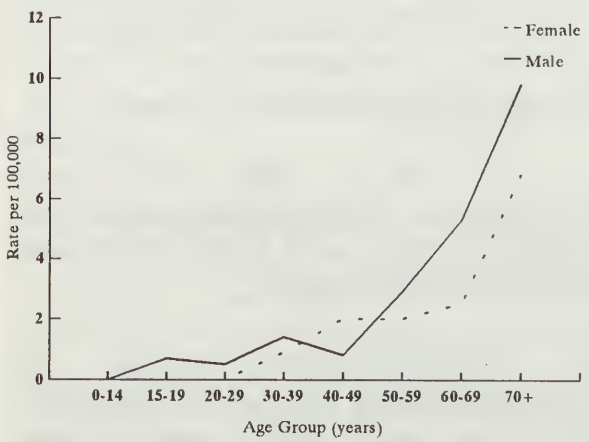


Fig 7. Legionellosis. Incidence by age group and sex. Maryland, 1994.

Of the the 46 on whom information was available, 23 (50%) were smokers of more than 10 cigarettes per day. Of the smokers, 3 had diabetes and 2 were undergoing immunosuppressivet therapy. Among the 17 (37%) non-smokers, 3 had diabetes, 1 was undergoing systemic corticosteroid treatment and 1 was undergoing other immuno-suppressive treatment. Thirteen (28%) patients had indicated no possible source of infection or predisposing factor(s). There were 5 deaths among the 71 cases with a known outcome for a case fatality rate of 7.0%.

LYME DISEASE (343)
6.9/10,000 (U.S. 4.4/10,000)

This summary is based on 343 cases confirmed by the University of Maryland Lyme Disease Project, rather than the 380 cases reported in Table 1 (see July 1995 issue). The project conducts surveillance in cooperation with Epidemiology and Disease Control Program, DHMH. In 1994, Lyme disease increased by 66% from 1993 (207) cases. This increased number of cases is mostly explained by a great improvement in the surveillance process due to the cooperation of physicians, laboratories, and local health departments. The trend for the past 8 years is shown in Figure 8. The highest rates per 100,000



Fig 8. Lyme disease. Cases reported, Maryland, 1987-1994.

population occurred in Kent (107.0), Queen Anne's (58.2), Cecil (44.1), and Caroline (38.3) counties.

Eighty-six percent of the 343 cases had onset of illness in May through October; the peak incidence was in June (98 cases) and July (86 cases). See Figure 9. The ratio of male to female cases was 1.26:1. Among the 319 cases with known race, 285 (89%) were white and 34 (11%) were non-white. Ages ranged from 1 to 84 years (mean 33 years). Thirty-five percent of the cases were 20 years of age or younger.

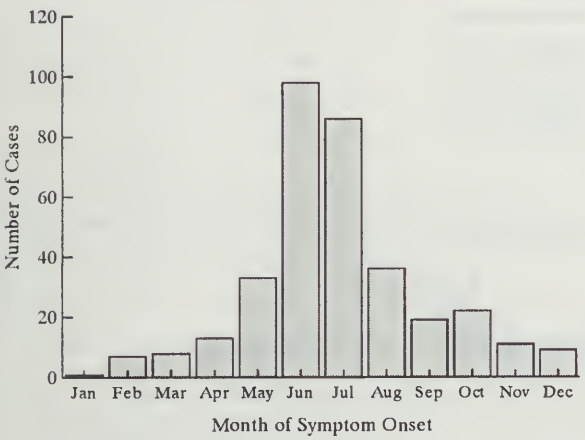


Fig 9. Lyme disease. Cases reported by month of symptom onset, Maryland, 1994.

A definite tick bite prior to the onset of illness was reported by 141 (41%) cases, 65 (19%) had uncertain exposure, and 137 (40%) had no known tick exposure.

Of the 343 cases, 235 (69%) had erythema migrans, 70 (20%) had arthritis, 37 (11%) had Bell's palsy, 11 (3%) had lymphocytic meningitis, 9 (3%) had radiculoneuropathy, 4 (1%) had cardiac symptoms, and 2 (1%) had encephalitis.

MALARIA (83)
1.7/100,000 (U.S. 0.4/100,000)

The number of malaria cases reported in Maryland in 1994 is shown in Table 1 (see July 1994 issue). These 83 cases represent a 48% increase over the average yearly number of cases reported since 1989. The observed increase in cases prompted the DHMH Epidemiology and Disease Control Program to issue a press release in December 1994, and to discuss malaria prophylaxis and travel precautions in a March 1995 Newsletter in the *Maryland Medical Journal*.

Nine counties and Baltimore City reported malaria cases in 1994; the majority of cases occurred in Prince George's (42%) and Montgomery (30%) Counties.

Incidence was noted to be higher in men (male:female rate ratio, 1.4:1), and non-white races (non-white:white rate ratio, 35:1). Cases ranged in age from one to 69 years; 75% of cases occurred in adults over 20 years of age; the 35-39 year age group had the highest incidence of disease (3.0/100,000).

All malaria cases were apparently imported. *Plasmodium falciparum* (39 cases), *P. malariae* (4 cases), and *P. ovale* (1 case) were acquired primarily in West Africa. *P. vivax* (16 cases) was acquired in East Africa, India, and Central America. Of the 36 cases reporting on travel prophylaxis, almost two-thirds admitted that no chemoprophylaxis was taken prior to their illness.

MEASLES (4)
0.08/100,000 (U.S. 0.34/100,000)

The 4 cases reported in 1994 matched the all time low reached in 1993. Two cases occurred in Baltimore County, and one each in Montgomery and Wicomico counties. Two cases were adults linked to out-of-state importation, one case was a 7 month old too young to be immunized, and one case was preventable, in a 23 month old. This last case was an international importation.

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Consistent with other reported research, another study (*Ann Emerg Med* 1995;25:751-755) has provided data indicating that **alterations in mental status, including delirium, may be present in up to 40% of elderly patients who present to emergency departments.** Age and severity of illness were positively correlated with mental status alterations. In a related editorial, Sanders (*Ann Emerg Med* 1995;25:831-833) cites studies showing that both dementia and delirium—an acute medical emergency requiring immediate evaluation—often go unrecognized. Discussing barriers to recognition of cognitive impairment and their implications, he states that cognitive impairment is no more a part of normal aging than otitis media is a normal part of childhood. Sanders recommends that brief formal screening examinations be performed to assess older patients for delirium and other altered mental states.

Concomitant use of nonsteroidal anti-inflammatory drugs (NSAIDs) and some antihypertensive agents (thiazide and loop diuretics, beta- and alpha-adrenergic blockers, and ACE inhibitors) may be associated with loss of blood pressure control. A randomized, double-blind, placebo-controlled multicenter study (*Arch Intern Med* 1995;155:1049-1054) indicates that **the addition of naproxen or ibuprofen does not cause an increase in blood pressure or pulse rate in patients with hypertension controlled by treatment with once daily verapamil.** Long-term (> 6 weeks) effects, however, are not known.

Morphine may have a more rapid onset of action and more prolonged analgesic effect when given rectally rather than orally. In a randomized crossover study, 34 patients with pain from advanced cancer who had not previously received opioid drugs received 10 mg morphine hydrochloride solution orally on two occasions and rectally on two occasions, along with oral or rectal placebo. Mean pain scores decreased significantly 10 minutes after administration of the rectal morphine solution, but not until 60 minutes after oral administration. After 180 minutes, pain relief was sustained only with rectal morphine (*J Clin Oncol* 1995;13:1004-1008).

Data reported to the Centers for Disease Control (CDC) indicate that in 1994, there were 34 974 cases of acquired immune deficiency syndrome (AIDS) among men whose only reported HIV exposure was sexual contact with other men. **According to the CDC, male-to-male sexual contact continues to represent the most frequently reported mode of HIV transmission among people with AIDS.** From January 1989 through June 1994, rates of AIDS-defining opportunistic illness among men who have sex with men (MSM) increased 31%. Increases also varied by race/ethnicity. During January–June 1989 and January–June 1994, rates were highest among black men (20.8 and 37.3 per 100 000 males aged 13, respectively). From January 1989 through June 1994, the largest proportionate increase in rate (79%) also occurred among black men. During the same period, the rate among white men increased 14%. Factors that may be associated with increased risk among ethnic/racial minorities include decreased access to HIV-prevention services, higher rates of sexually transmitted diseases, and culturally inappropriate HIV-prevention activities (*MMWR Morb Mortal Wkly Rep* 1995;44:401-404).

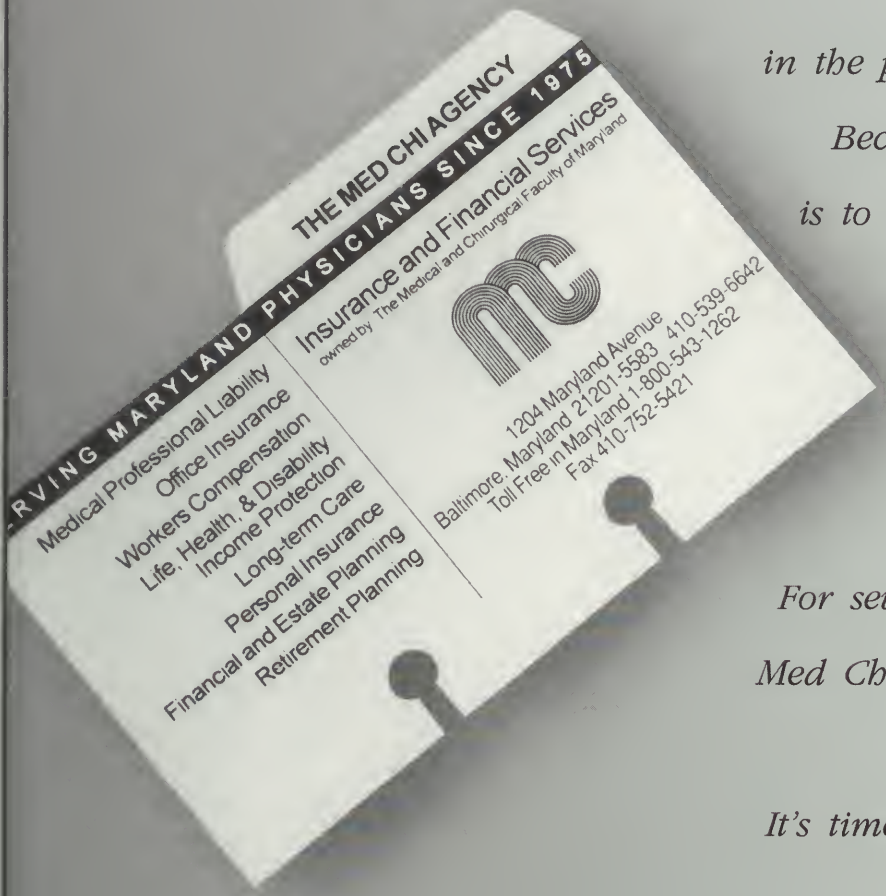
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To evaluate the cardiovascular fitness of a group of patients with end-stage osteoarthritis prior to their undergoing total joint arthroplasty of the hip or knee, 37 patients were compared with 23 age- and sex-matched healthy volunteers without arthritis (*Arthritis Rheum* 1995;6:799-805). Results showed that **patients with chronic disability and pain due to severe osteoarthritis demonstrate severe cardiovascular deconditioning.** Ten patients (37%) had findings suggestive of congestive heart failure (CHD), compared to 3 of the controls (13%), a trend that did not reach statistical significance at the 5% level, but which warrants further investigation given data indicating that exercise intolerance has predictive value for myocardial infarction and death from CHD. Citing data showing the benefits of fitness walking/aquatic exercise in patients with osteoarthritis, the study investigators emphasize the importance of recommending and facilitating exercise habits for arthritis patients.

During 1994-1995, health departments in 13 states (not Maryland) reported to the Centers for Disease Control cases of salmonellosis in people who had direct or indirect contact with a reptile (snakes, lizards, or turtles) from which the same *Salmonella* serotype was isolated. The cases are consistent with previous reports indicating that direct contact with a reptile is not necessary for transmission of *Salmonella*. Severe complications of *Salmonella* infection, including septicemia and meningitis, may occur in young children, immunocompromised persons, and infants during the peripartum period. In the United States, an estimated 7.3 million pet reptiles are owned by approximately 3% of households. A high proportion of reptiles are asymptomatic *Salmonella* carriers. Fecal carriage rates can be more than 90% (*MMWR Morb Mortal Wkly Rep* 1995;44:347-350).

A study to determine which consumer products are commonly involved in ocular trauma indicates that approximately 298 000 cases involving 500 different products were treated in hospital emergency rooms during 1991 (*J Natl Med Assoc* 1995;87:349-352). **The leading causes of consumer product-related eye injury were contact lenses** (26 490 ER visits), **welding equipment** (12 771 visits), **hair curlers/curling irons** (5946 visits), and **workshop power grinders** (5476 visits).

A study comparing **the Vita-Stat automated blood pressure computer** (a patient-operated device widely available in many communities in grocery stores and pharmacies) with the mercury sphygmomanometer indicates the Vita-Stat **produces inaccurate, poorly reproducible results** (*Arch Fam Med* 1995;4:419-424) Study subjects were 63 passersby (21 each in 3 stores) ranging in age from 18 to 87 (average, 62); 54% were women and 92% were white. Of the 62 who completed the study (one woman dropped out for unspecified reasons), 31 said they were hypertensive, 19 said they were normotensive, and 12 were unsure. BP measurements were made with each subject simultaneously wearing a Vita-Stat cuff on the left arm and a mercury sphygmomanometer cuff on the right arm; two measurements were taken sequentially. In 63.2% of the subjects, Vita-Stat readings were more than 5 mm Hg different from the mercury readings. Vita-Stat systolic readings were usually lower than mercury readings, but varied by as much as 60 mm Hg below in one patient to 58 mm Hg above in another. The authors conclude that the Vita-Stat is not appropriate as a BP monitoring device and suggest that physicians warn their patients not to rely on Vita-Stat measurements in assessing BP.



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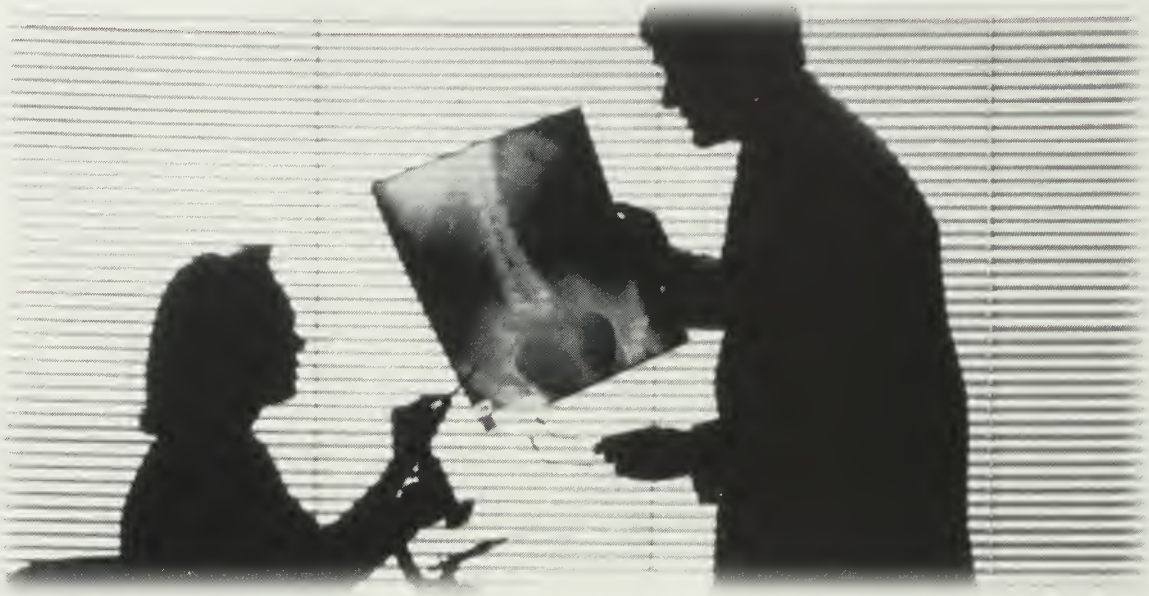
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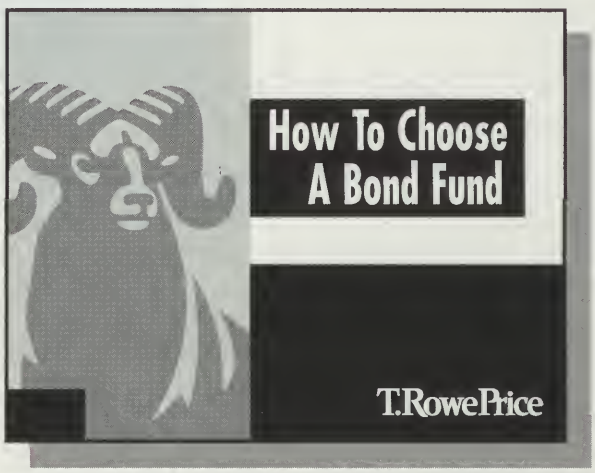
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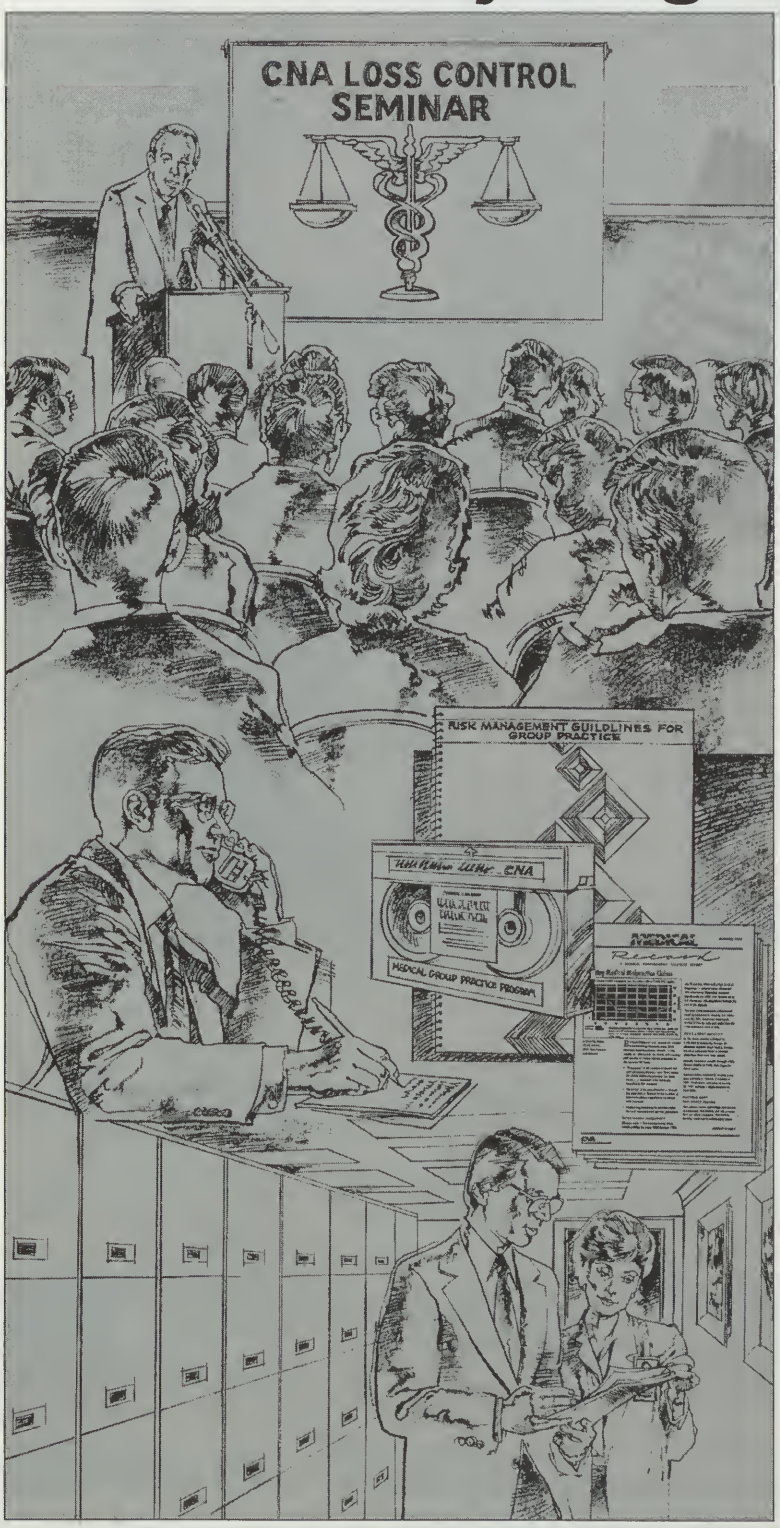
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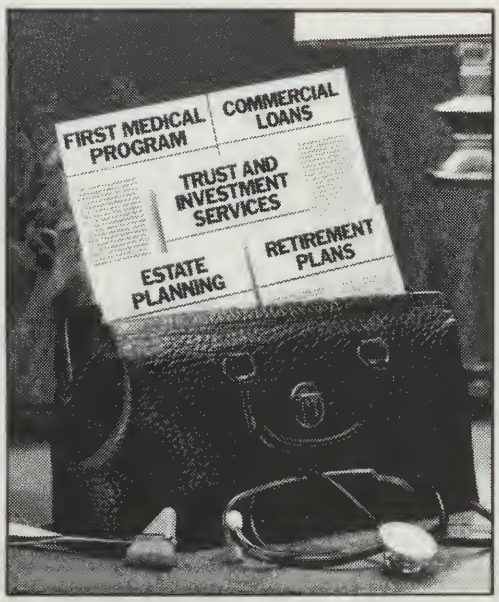
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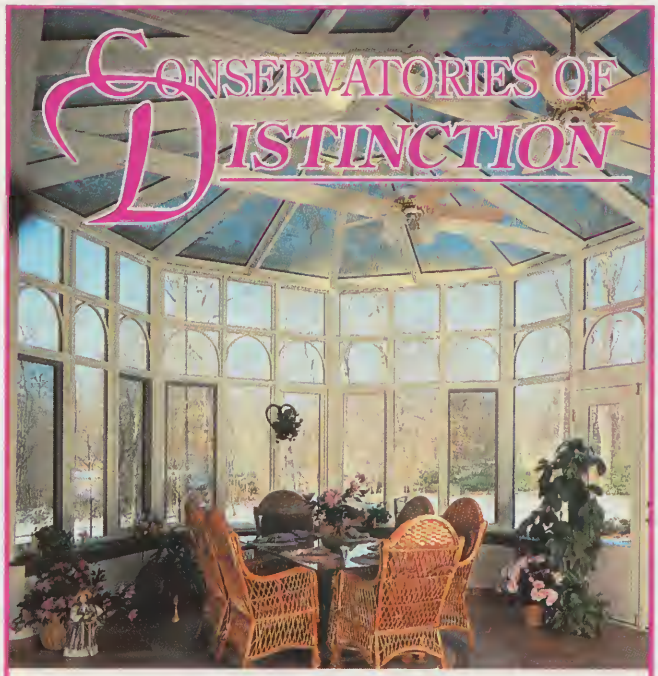
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Address Update

A few weeks ago you should have received an address update form from Med Chi. I urge you to complete and return this form in the postage-paid envelope that you received with the form as soon as possible. In order to effectively communicate with you as a member of this organization, it is very important that we have your most current address and telephone number. If you did not receive this form, or are unable to locate it, please contact Wanda Griebel in the membership department at 410-539-0872 or 1-800-492-1056, ext. 330.

Solicitation of Nomimations to the Board of Physician Quality Assurance (BPQA)

Pursuant to §14-202 of the Health Occupations Article of the Annotated Code of Maryland, all licensed physicians in Maryland wishing to nominate candidates for the initial vacancies on the Board of Physician Quality Assurance (BPQA) must submit nominations by October 1, 1995. Persons making nominations must certify that the nominee is willing to serve and is a practicing licensed physician as required by §14-202. All nominations must include a two- to three-page *curriculum vitae* of the candidate. Nominations must be submitted to the city/county medical society in the nominees' geographic area. For a list of city/county medical societies, contact the office of the Chief Operating Officer at The Medical and Chirurgical Faculty of Maryland, 410-539-0872 or 1-800-492-1056.

Please note that the election to select the names of physicians to be submitted to the Governor for possible nomination to the BPQA is open to all licensed physicians in Maryland. This election will be held on April 27, 1996, at the Turf Valley Hotel and Country Club, Ellicott City, Maryland. The time of balloting and a list of nominated candidates will appear in the March issue of the *Maryland Medical Journal*.

George Elias' Battery Conviction Reversed

The Maryland Court of Appeals has reversed the battery conviction of E. George Elias, M.D., a prominent oncological surgeon in Baltimore City, and one of Med Chi's members. Med Chi, through the general counsel's office, submitted a brief on behalf of Dr. Elias, as *amicus curiae* in the Maryland Court of Appeals.

Dr. Elias was originally charged with battery and a fourth degree sexual offense by a patient upon whom he was performing a breast examination, but during the course of it, Dr. Elias noticed some unusual spots on the patient's right thigh, and after discussing them with her, he palpated the lymph nodes in her groin area. No chaperon was present during this examination, and the patient later charged that Dr. Elias conducted this intimate examination without her consent.

Dr. Elias was acquitted of the sexual offense, but convicted of battery in the Baltimore City District Court on April 9, 1993, even though the trial judge expressed a belief that Dr. Elias had not intended any harm to the patient and that there was a genuine "misunderstanding" between them. Dr. Elias then appealed to the Circuit Court for Baltimore City, where the judge affirmed his conviction for battery and increased the $500 fine imposed by the District Court to $10,000. A subsequent appeal was taken to the Maryland Court of Appeals, and it is on this appeal that the reversal has taken place. There can be no further appeal, and Dr. Elias now stands exonerated by Maryland's highest court.

Med Chi is extremely gratified at the ultimately favorable decision of the Court of Appeals on behalf of Dr. Elias. His convictions on criminal counts of battery in the lower courts have caused real apprehension on the part of Maryland phy-

sicians that they could be unjustly convicted of criminal activity in conducting a good-faith physical examination that must, necessarily, involve touching the patient's body in intimate places. This case also illustrates, however, the wisdom of having a chaperon present whenever it can reasonably be expected that a physical examination may involve such intimate touching.

Source: Angus R. Everton, Esq., former counsel to Med Chi.

Med Mutual Victorious in Appeal

In June 1995, the Medical Mutual Liability Society of Maryland (Med Mutual) was granted a reversal of damages in its appeal against B. Dixon Evander and Associates, Inc. (Evander, Inc.)

During the 1980s, clients of Evander, Inc., were insured by Med Mutual. In 1988, Evander, Inc., became a "master agent" for PIE Mutual. On the basis of the promotion of a competing insurer by Evander, Inc., Med Mutual decided to terminate the relationship. As a result, physicians insured with Med Mutual could no longer use Evander, Inc., as their broker, and many selected a different broker or insured directly with Med Mutual. In May 1990, Evander, Inc., filed a tort suit against Med Mutual and two counts went to jury — defamation and wrongful interference with business relationships. The jury was unable to reach a verdict on the defamation count, but the jury found in favor of the plaintiffs on the wrongful interference count.

The recent appeal was on a multi-million dollar award originally levied against Med Mutual regarding the termination of Evander, Inc., as a broker for Med Mutual. The appeals court found that "since the plaintiffs' evidence of causation was insufficient, the award of compensatory and punitive damages must be reversed." Plaintiffs are to pay costs.

Healthcare Networks, Inc.

The AMA provided the following information concerning Healthcare Networks, Inc. (the parent company of AllNet):

> Healthcare Networks, Inc., which is incorporated in Arizona, has lost its membership in the Better Business Association "due to questions regarding the company's business practices and affiliations."

CLIA Update

Physician-performed microscopy has been changed to provider-performed microscopy to allow for dentists and mid-level practitioners (i.e., nurse practitioners, nurse midwives, physician assistants) to perform the tests specified under this category.

The provider-performed microscopy list now includes: nasal smear examination for granulocytes; fecal leukocyte examinations; qualitative semen analysis (presence or absence of sperm and motility); wet mount examination of expressed prostatic secretions; all direct wet mount preps for detection of bacteria, fungi, parasites, and human cellular elements; all KOH preparations; pinworm examinations; fern tests; post-coital direct, qualitative examinations of vaginal or cervical mucous; and urine sediment examinations.

The certificate of waiver allows for the performance of the following tests: urine dipstick or tablet tests - non-automated; fecal occult blood; urine pregnancy tests - visual color comparison tests; ovulation tests-visual color comparison for human luteinizing hormone; erythrocyte sedimentation rate - non-automated; hemoglobin by copper sulfate - non-automated; hemoglobin by single analyte instruments providing direct measurement and readout; spun micro-hematocrit; and blood glucose by glucose monitoring devices cleared by the FDA for home use.

Indemnification or Hold Harmless Clauses

Many managed care organizations (MCO) have provider agreements that have a hold harmless or indemnification clause. An indemnification clause is a way to shift the risk from the MCO to the physician. The clause means that if an action or investigation is commenced against the physician that involves the MCO, the physician will be responsible for the costs incurred as a result of the action. Some professional liability insurers take the position that a physician who signs a provider agreement in which the physician assumes liability or expenses for an MCO is in breach of his insurance contract. Therefore, physicians should always request the carrier's written opinion about the extent to which its insurance policy covers liabilities raised by indemnification or hold harmless clauses. Furthermore, physicians should always consult legal counsel before signing a contract containing an indemnification clause.

AMA Launches Medicare Overhaul Plan

The AMA has launched a plan to overhaul Medicare. Some of the points covered by the AMA plan are: 1) restructured cost/sharing: $500 refundable annual deductible; $500 Part A premiums; no co-insurance; 2) price controls eliminated; 3) increased premium for wealthy beneficiaries; deductible lowered or eliminated for poor beneficiaries; and 4) allowing beneficiaries to choose among participating private plans with fixed government contribution or allowing beneficiaries to establish medical savings accounts with catastrophic insurance. The intent of the AMA plan, according to President-elect Daniel H. Johnson, Jr., M.D., is to "create a more cost-effective market place" with enhanced price consciousness for both patients and physicians.

According to the AMA, the proposal would:

a. save as much as $162 billion from projected Medicare spending over the next seven years;
b. result in savings for most Medicare beneficiaries;
c. improve the quality of American health care;
d. offer more choices per patient while requiring greater individual responsibility;
e. increase cost consciousness by patients and physicians;
f. uphold the clinical judgment of Medicare physicians;
g. decrease modestly the Medicare subsidy for high income beneficiaries;
h. reduce bureaucratic hassles and red tape;
i. fight waste and fraud; and
j. limit care of marginal value.

Study Group in Alternative Medicine

The next meeting of the Study Group in Alternative Medicine will be held on Wednesday, September 13, 1995, at 7:30 p.m. at Med Chi. Margaret Mullins, M.D., will discuss auriculotherapy, a form of acupuncture confined to placement of needles in the external ear. Dr. Mullins practices internal medicine in Annapolis.

Please call Steve Jones at Med Chi at 410-539-0872 or 1-800-492-1056, or Hiroshi Nakazawa, M.D. at 410-644-1502 if you wish to attend or have questions regarding the study group. Light refreshments will be served.

Attention WWII Veterans

A special issue of the *MMJ*, dedicated to Maryland physicians' service in World War II, is currently being planned. If you are a veteran of World War II and would be willing to discuss your experiences as a physician during that era, please contact MaryAnn Ayd, managing editor, *MMJ*, no later than September 15, at 410-539-0872 or 1-800-492-1056, ext. 305.

Computer Donations Sought

Back to Basics, a program at West Baltimore's Lexington Terrace that enables participants to get off public assistance by teaching them how to transcribe medical records, is seeking computer donations. Anyone interested should call the program's instructor, C. Sherwood Harris, at 410-494-0694.

Baltimore City Medical Society Receives National Recognition

The Baltimore City Medical Society was elected to the Associations Advance America Honor Roll in the Associations Advance America Awards Program in recognition of its Stop Smoking Hotline held November 17, 1994. Over 55 calls were made to the hotline on the day of the event. Callers spoke directly with physicians and received smoking cessation counseling. This awards program, sponsored by the American Society of Association Executives, recognizes significant contributions to society by associations in areas such as community service, education, professional standards, codes of ethics, and product and safety standards.

Health Care Contracts and Policies

As part of its Private Sector Advocacy Team (PSAT) program, the AMA is gathering information on health plan contracts and policies as well as patient treatment problems such as denial of care. The goal is to obtain a realistic, documented view of the relationship between physicians and managed care organizations' health plans. This information is needed to help build evidence for advocacy programs and to enable the AMA to tell medicine's story effectively to the media, the public, Congress, and state legislators. It will also enable the AMA to help physicians in relations with health plans.

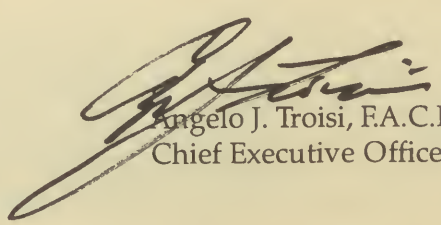
Any physicians who have experienced problems with managed care organizations, including denial of care, deselection, reduced reimbursement, contractual "gag rules," or any other policies or procedures that interfere with good medical practice and patient care, are encouraged to contact Carol O'Brien, JD, PSAT senior attorney, at 312-464-4367.

Physician Groups Awarded Grants

Expanding on its efforts to encourage physicians to find innovative ways to meet the needs of people who have difficulty obtaining proper health care, The Robert Wood Johnson Foundation's "REACH OUT" program awarded planning grants to 18 private physicians' groups in 17 communities throughout the United States, totaling $1.6 million. In addition, the Foundation awarded $3.8 million in implementation grants to 19 private physicians' groups, which last summer received planning grants under the REACH OUT program. In Maryland, planning grants were awarded to New Song Health Center in Baltimore and to Primary Care Coalition of Montgomery County in Rockville.

New EMS Palliative Care/DNR Protocol

The Maryland EMS Palliative Care/Do-Not-Resuscitate (DNR) Program, approved by the Board of Physician Quality Assurance, went into effect for ALS and BLS providers as of July 1, 1995. Details on the new protocol, and examples of the order form and bracelet can be found on pages 717-722 of this issue of the *MMJ*.



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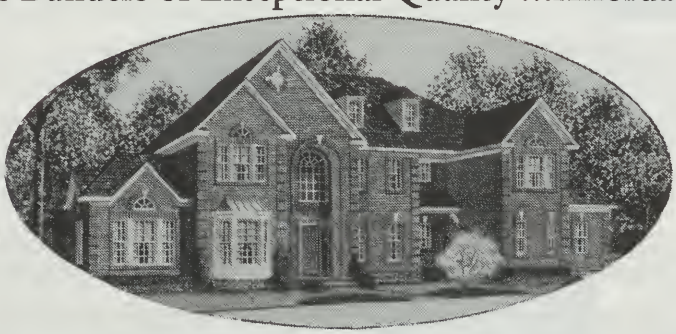
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Friday, October 20

H. Pylori and Peptic Ulcer Disease
Robert M. Strauss, MD
Assistant Professor of Medicine
Digestive Diseases
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Recent Advances in Abdominal Imaging
Frederick B. Murphy, MD
Associate Professor of Radiology
Emory University School of Medicine

Laparoscopic Surgery in 1995–
Panacea or Technology Run Amuck
Gene Branum, MD
Assistant Professor of Surgery
Division of Gastrointestinal Surgery
Emory University School of Medicine

Multispecialty Panel Case Presentations–
Gastroenterology, General Surgery, Radiology

Saturday, October 21

Infectious Diseases Update–Understanding the Impact of Antibiotic Resistance
Stephen Schwarzmann, MD
Associate Professor of Medicine
Chief of Infectious Disease
Emory University Hospital

Asthma Update–Current Diagnosis and Treatment
Jeffrey R. Pine, MD
Associate Professor of Medicine
Pulmonary and Critical Care

Hypertension 1995–
Part I: The Search for Secondary Causes
James A. Tumlin, MD
Assistant Professor of Medicine
Renal Division
Emory University School of Medicine

Multispecialty Panel Case Presentations–
Infectious Diseases, Pulmonary Medicine, Nephrology

Sunday, October 22

Preoperative Medical Evaluation
Donald C. Davis, MD, PhD
Associate Professor of Medicine
General Internal Medicine
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Hypertension 1995–
Part II: A Rational Approach to Accelerated Hypertension
James A. Tumlin, MD

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Members in the News



ROSEMARY HATEM BONSACK, M.D., delegate to the Maryland General Assembly from the 34th district, has been appointed by the speaker of the House of Delegates, Casper R. Taylor, Jr., as alternate delegate to the Committee on Children, Families and Health for the National Conference of State Legislatures in Milwaukee. In addition, Dr. Bonsack has been awarded the Regional Women of Distinction Award by Soroptomist International. Vice-chairperson of the Rules and Executive Nominations Committee and a member of the Ways and Means Committee and the Joint Committee on Health Care Delivery and Financing, Dr. Bonsack has been a member of the House of Delegates since 1990. She is a past president of the Harford County Medical Society and the Maryland Academy of Family Physicians. She received her medical degree from the Medical College of Pennsylvania and presently has a limited practice of family medicine in Aberdeen, Maryland. Dr. Bonsack is a member of the American Academy of Family Physicians and the Harford County Mental Health & Associations Advisory Committee.



HOWARD M. EISENBERG, M.D., has been elected to serve a one-year term as chairperson of the board of directors for the American Board of Neurological Surgery. A professor of neurological surgery at the University of Maryland Medical Center, Dr. Eisenberg is chief of the division of neurotrauma, director of medical services and director of the program in trauma at the R Adams Cowley Shock Trauma Center in Baltimore. After receiving his medical degree from the State University of New York Downstate Medical Center in New York City, he was an intern, resident, and assistant surgeon at the New York Hospital in New York City. A neurological surgery resident at Children's Hospital Medical Center and Peter Bent Brigham Hospital in Boston, Dr. Eisenberg was a fellow in surgery at Cornell University in New York, a fellow in neurology at the National Hospital for Nervous Disease in London, England, and a clinical fellow in surgery at the Harvard Medical School. He is a diplomate of the American Board of Neurological Surgery, a founding member of the American Society for Pediatric Neurosurgery, and a member of more than 30 professional and scientific societies. Dr. Eisenberg is the author of five books and more than 200 scientific articles, abstracts, and book chapters. In addition, he is a consulting editor for *Brain Injury and Recovery* and on the editorial boards of the *Journal of Neurosurgery*, *Brain Injury* and the *Journal of Neurotrauma*.

CHARLES F. HOBELMANN, JR., M.D., a graduate of the University of Maryland School of Medicine, has recently been named chief of staff at Children's Hospital in Baltimore, Maryland. Dr. Hobelmann completed his internship and anesthesiology residency at the Naval Regional Medical Center in San Diego, California. Following his medical training, he worked as a lieutenant commander at the Naval Regional Medical Center in San Diego until his return to Baltimore. A fellow of the American College of Anesthesiology, and past president of the Maryland/DC Society of Anesthesiologists, Dr. Hobelmann is a member of many professional societies. In addition, he was appointed to the American Board of Anesthesiology as an associate examiner and to the Maryland Board of Physician Quality Assurance. Dr. Hobelmann is an instructor in anesthesiology at The Johns Hopkins Hospital and he has published several scientific articles. He is also on the medical staff of Union Memorial Hospital in Baltimore.



GEORGE S. MALOUF, SR., M.D., a 25-year leader in the field of ophthalmology and public health in Maryland, has been named chairperson of the Maryland Health Resources Planning Commission (HRPC) by Governor Parris N. Glendening. Dr. Malouf, first appointed to the HRPC in 1990

by then-Governor William Donald Schaefer, was also one of the founding members of the Prince George's County Health Planning Advisory Committee. Former chief of ophthalmology at Prince George's County General and Doctor's hospitals, he was appointed as a member of the board of directors at Prince George's General Hospital and Dimensions Inc. Dr. Malouf is a past president of Med Chi, the Prince George's County Medical Society, and the Maryland Society of Eye Physicians and Surgeons. He currently serves as chairperson of the Maryland Delegation to the American Medical Association and is a member of the American Board of Ophthalmology. Dr. Malouf received his medical degree from the French Faculty of Medicine in Beirut, Lebanon. After completing his residency training at Boston City Hospital, he served in the U.S. Army Medical Corps. Dr. Malouf has received many awards for his work in the health care community, including the AMA's Benjamin Rush Award for Citizenship and Community Service and the A. H. Robins Award for Community Service. He was named Prince Georgian of the Year in 1988. He maintains a private practice in Hyattsville with his sons, Alan Malouf, M.D., and George Malouf, Jr., M.D.



RON TEICHMAN, M.D., M.P.H., was elected president of the Maryland College of Occupational and Environmental Medicine, one of 31 component societies of the American College of Occupational and Environmental Medicine (ACOEM). President of Teichman Occupational Health Associates, Inc., in Towson, Maryland, he has served as the medical director of a network of free-standing occupational health centers and as a regional medical director for the General Motors Corporation. Dr. Teichman received his medical degree from New York Medical College and his master's degree in public health in occupational medicine from Columbia University in New York City. He completed an internal medicine residency at the North Shore University Hospital in Manhasset, New York. He is a fellow of the American College of Physicians (ACP), ACOEM, and the New York Academy of Medicine. Chairman of the Committee on Ethical Practice in Occupational Medicine for the ACOEM, Dr. Teichman is the official representative to the ACP and serves on the editorial board of the *Journal of Occupational and Environmental Medicine.*

UMBILICAL CORD BLOOD TRANSPLANTS

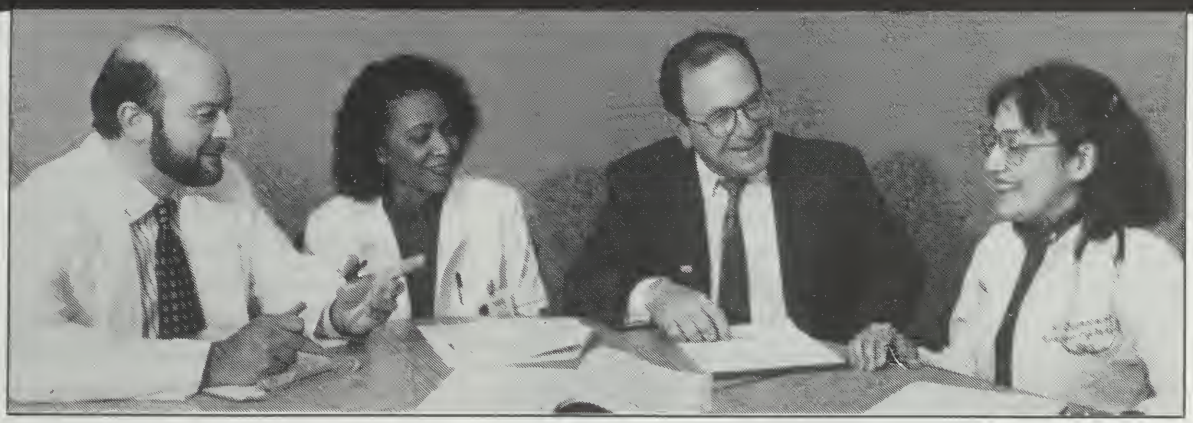
Blood harvested from the placenta and umbilical cord of newborns, which contains the same stem and progenitor hematopoietic cells found in bone marrow, may offer a new approach in the treatment of cancer, blood disorders, and other serious illnesses. According to a recent report,[1] the potential advantages of cord blood have caused burgeoning interest in cord blood transplants as an alternative to bone marrow transplants.

Cord blood can be obtained noninvasively at the time of delivery with no risk to mother or infant and stored for months or years. Because cord blood-derived stem cells appear to be less immunoreactive than stem cells derived from bone marrow, the need to match donor and recipient may be somewhat less stringent than with bone marrow transplants. Cord blood also is less likely than donated adult bone marrow to harbor infectious agents.

One potential disadvantage is the limited size of the sample. Although cord blood is known to contain enough stem cells to treat children, it remains uncertain whether it contains sufficient stem cells to treat adults. Other unanswered questions include the minimal cell dose and whether a given cord blood unit is safe or of adequate size.

1. Stephenson J: Terms of engraftment: umbilical cord blood transplants arouse enthusiasm. *JAMA* 1995;273:1813-1815.

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Addressing the National Institutes of Health Consensus Development Conference on Total Hip Replacement last September, **David S. Hungerford, M.D.,** chief of orthopedic surgery at Good Samaritan Hospital in Baltimore, described clinical experience with and the current status of proximally coated cementless femoral stems (*Total Hip Replacement.* NIH Consensus Statement 1994, Sep 12–14;12(5): 1–131). **Ellen J MacKenzie, Ph.D.,** professor of health policy and management at The Johns Hopkins University School of Hygiene and Public Health, was a member of the consensus development panel.

Christoph Stein, M.D., an assistant professor of anesthesiology and critical care medicine at The Johns Hopkins University School of Medicine, is the author of a review article (*N Engl J Med* 1995;332:1685–1690) on opioid pain control in peripheral tissue.

Edward J. Lee, M.D., and **Charles A. Schiffer, M.D.,** are among the authors of a study indicating that in elderly patients with primary acute myelogenous leukemia, granulocyte-macrophage colony-stimulating factor does not decrease the severe myelosuppressive consequences of initial chemotherapy or improve response rate (*N Engl J Med* 1995;332:1671–1677). Dr. Lee is an associate professor and Dr. Schiffer is a professor of medicine and oncology at the University of Maryland Medical Center.

Ebenezer Israel, M.D., M.P.H., director of the epidemiology and disease control program of the Maryland Department of Health and Mental Hygiene, is among the authors of a study indicating that combining a geographic information system with case-control epidemiologic methods may be useful in identifying risk factors associated with vector-borne infectious diseases. The study examined environmental risk factors for Lyme disease in Baltimore County (*Am J Public Health* 1995;85:944–948).

Douglas P. Beall, M.D., of the department of radiology at The Johns Hopkins Hospital, is co-author of an editorial published in the resident physicians section of the *Journal of the American Medical Association* (1995;273:1968) on the potential effects of federal budget cutting on medical school loan deferments.

Charles Yeo, M.D., an associate professor of surgery at The Johns Hopkins University School of Medicine, is the lead author of a study (*Ann Surg* 1995;221:721–733;) indicating that the best predictors of long-term survival after pancreaticoduodenectomy are a normal chromosome count in the tumor cells; small tumor size; no metastasis to the lymph nodes; whole tumor removal; surgery in the 1990s; chemotherapy and radiation following surgery; and minimal or no damage to the p53 tumor-suppressor gene.

Ronald H. Gray, M.D., is the lead author of a study indicating that there is no excess risk of spontaneous abortion among pregnancies conceived during natural family planning use, but that in women with a history of pregnancy loss, there is an increased risk of spontaneous abortion associated with preovulatory or postovulatory delayed conceptions (*Am J Obstet Gynecol* 1995;172:1567–1572). Dr. Gray is a professor of population dynamics at The Johns Hopkins University School of Hygiene and Public Health.

Gabor D. Kelen, M.D., an associate professor of emergency medicine at The Johns Hopkins University School of Medicine, is the lead author of a prospective observational study of blood and body fluid contacts with specific body areas during commonly performed emergency department procedures (*Ann Emerg Med* 1995;25:743–750). Study results indicate that gloves should be worn during virtually all ED procedures; barrier protection for the body may be needed for all but the simplest procedures; and face protection should be used during invasive procedures.

John S. Andrews, M.D., and **Catherine D. DeAngelis, M.D.**, are the authors of an update on major advances and developments in pediatrics published in the 1995 Contempo issue of the *Journal of the American Medical Association* (1995;273:1708–1710). Dr. DeAngelis is the vice dean for academic affairs and faculty at The Johns Hopkins University School of Medicine. Dr. Andrews is an instructor in pediatrics at Hopkins medical school and a staff member at the Johns Hopkins Children's Center.

Henry A. Pitt, M.D., a professor of surgery at The Johns Hopkins University School of Medicine, is the lead author of a prospective analysis indicating that in patients with localized perihilar cholangiocarcinoma, surgical resection prolongs survival and radiation therapy has no effect on survival or late toxicity (*Ann Surg* 1995;221:788–798).

Safuh Attar, M.D., a professor of thoracic and cardiovascular surgery at the University of Maryland Medical Center, is the lead author of a literature review of paraplegia complicating thoracotomy for pleural or pulmonary disease and surgical procedures for malignant hypertension (*Ann Thorac Surg* 1995;59:1410–1416). Dr. Attar's co-authors from the University of Maryland are **John R. Hankins, M.D., Stephen Z. Turney, M.D., Mark J. Krasna, M.D.**, and **Joseph S. McLaughlin, M.D.**

John K. Niparko, M.D., and **Michael E. Johns, M.D.**, are the authors of an update on major advances and developments in otolaryngology-head and neck surgery published in the 1995 Contempo issue of the *Journal of the American Medical Association* (1995;273:1705–1706). Dr. Niparko is an associate professor of otolaryngology-head and neck surgery and Dr. Johns is dean of the medical faculty and vice president for medicine at The Johns Hopkins University School of Medicine.

David A. Stone, M.D., a former fellow in cardiology at the University of Maryland Medical Center, is the lead author of a multiplane transesophageal echocardiographic study indicating that ulcerated atherosclerotic plaques in the thoracic aorta are associated with cryptogenic ischemic stroke and should be considered a potential source of cerebral emboli (*Am Heart J* 1995;130:105–108). Dr. Stone's co-authors from the University of Maryland include **Mary W. Hawke, M.D., Marian LaMonte, M.D., Steven J. Kittner, M.D., Joseph Acosta, M.D., Mary Corretti, M.D., Thomas R. Price, M.D.**, and **Gary D. Plotnick, M.D.**

Marvin M. Schuster, M.D., is the co-author of a study indicating that four easily detectable congenital markers (number of digital arches, presence of mitral valve prolapse, presence of joint laxity, and onset of constipation before age 10) may be helpful in diagnosing chronic intestinal pseudoobstruction (*Am J Gastroenterol* 1995;90:922–926). Dr. Schuster is chief of the division of digestive diseases at Johns Hopkins Bayview Medical Center.

Andrew L. Dannenberg, M.D., M.P.H., is the lead author of a review of New York City medical examiner records indicating that homicide and other injuries are major contributors to maternal mortality (*Am J Obstet Gynecol* 1995;172:1557–1564). Dr. Dannenberg is the director of the preventive medicine residency program at The Johns Hopkins University School of Hygiene and Public Health.

Paul D. Blumenthal, M.D., M.P.H., of the department of obstetrics and gynecology at Johns Hopkins Bayview Medical Center, is the author of a descriptive prospective study indicating that the Ramathibodi uterine manipulator is an effective alternative to currently available instruments for providing uterine elevation during laparoscopic sterilization procedures (*Fertil Steril* 1995;64:204–207).

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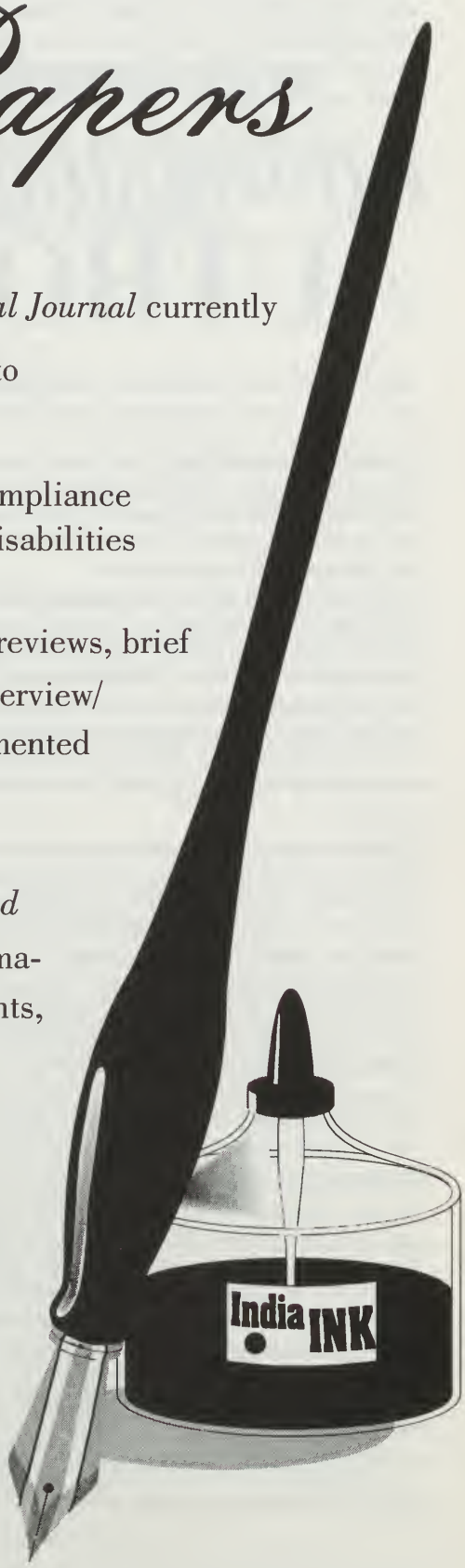
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- ***Letter of transmittal***—The letter of transmittal, which all authors must sign, should include the full names, degrees, titles, and affiliations of all authors, and the name, address, and phone number of the author to whom reprint requests and correspondence should be sent.

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  In addition, the letter must include a paragraph that transfers copyright ownership to the *MMJ* in the event that the work is published.

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  All material, including references, tables, and legends, must be double-spaced. Pages should be numbered. (All abbreviations should be spelled out on first use.) The original manuscript plus one copy should be submitted on standard (8.5" x 11") bond paper. If at all possible, an IBM-compatible disk should be included, with the manuscript entered in a WordPerfect, Multimate, Wordstar, or ASCII format; the transmittal letter should identify the format used.

- ***References***—References are limited to those citations noted in the text. References should be numbered consecutively as they appear in the text and should be kept to a minimum (fewer than thirty-five). Personal communications and unpublished data are not acceptable. At a minimum, references should include names of all authors, complete title of the article cited, name of journal abbreviated according to *Index Medicus* (if abbreviation is not known, journal name should be spelled out fully), year of publication, volume number, and first and last page numbers. Sample references are as follows:

  1. Stevens MB. The clinical spectrum of SLE. Md Med J 1991; 10:875–85.
  2. Ropes MW. Characteristics, manifestations, and pathologic findings. In: Ropes MD, ed. Systemic Lupus Erythematosus. Cambridge, MA: Harvard University Press. 1976; 50–4.

- ***Tables***—Tables should be typed on separate sheets of paper, be numbered, and have a brief descriptive title. Data presented in tables should be self-explanatory and should supplement, not duplicate, the text; the Editor reserves the right to edit tables. Authors should be sure that statistics are consistent in both tables and text.

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Acute outpatient care and comprehensive management of acute myocardial ischemia in chest pain emergency departments

Raymond D. Bahr, M.D., F.A.C.P., F.A.C.C.

Dr. Bahr is the medical director of The Paul Dudley White Coronary Care System at St. Agnes Hospital in Baltimore, Maryland.

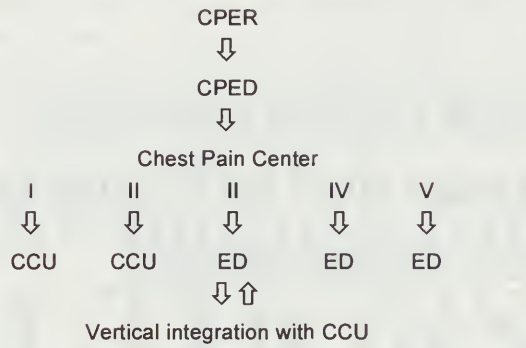
Reprints: *Raymond D. Bahr, M.D., St. Agnes Hospital, 900 Caton Ave., Baltimore, MD 21229*

In many hospital emergency departments, management of patients with chest pain (myocardial infarction, myocardial ischemia, and nonischemic chest pain) does not receive the attention it deserves.[1] Myocardial ischemia is a better term for chest pain than myocardial infarction (MI), in that only 10% of patients who present with chest pain turn out to have an acute MI.[2] What is needed is a comprehensive management scheme for the remaining 90% of patients.[2]

Patients with myocardial ischemia have hearts that are in trouble and are at risk for death if not properly managed. The term *myocardial ischemia* is the medical equivalent of *trauma* and should be treated with the same amount of respect. The goal is early intervention to prevent additional problems from developing. With the old mindset, patients who presented to the emergency department (ED) with chest pain and suspected MI would be transferred quickly to the coronary care unit (CCU) for at least two to three days of evaluation. We now realize that 70% of patients in CCUs turn out not to have an MI.[3]

Low-risk myocardial ischemia patients have been defined as those with a 20% chance of ischemia and 80% chance of ischemia ruled out. By contrast, high-risk myocardial ischemia patients are those with an 80% risk of acute ischemia and 20% chance of ischemia ruled out. Many of the low-risk patients do not necessarily need to be admitted to the hospital. Management in the future will include an acute outpatient evaluation in the ED according to protocol algorithms now being developed by academic medical centers and hospital chest pain centers. The algorithms separate patients who require hospital admission from those who do not and are a method of triage to integrate the chest pain emergency department (CPED) with the CCU (**Figure 1**).

Figure 1. Integration of the chest pain emergency department with the coronary care unit



Differential diagnosis

Patients with myocardial ischemia may present with symptoms other than chest pain, such as syncope, hypotension, shock, arrhythmias, atrial and ventricular arrhythmias, heart block, congestive heart failure, and flash pulmonary edema. Electrocardiograms (ECGs) and enzyme level measurements may be useful to rule in myocardial ischemia/infarction for such patients. Patients who present with only chest pain, however, can be rapidly assigned to one of five tracts to separate infarction, ischemia, and nonischemia presentations (**Figure 2**).

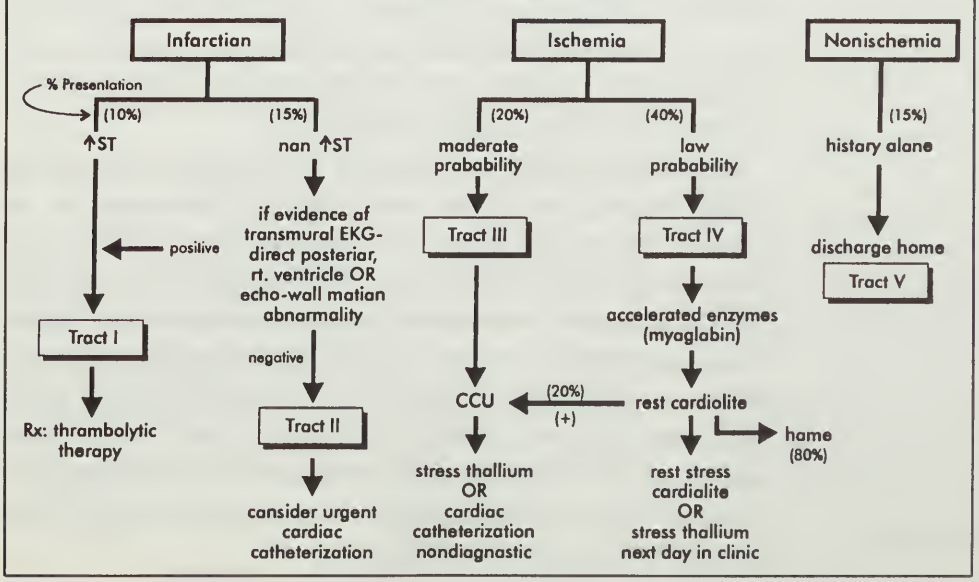
Infarction: Tracts I and II

Patients who present with prolonged, severe chest pain accompanied by ST elevation are assigned to Tract I, which includes consideration for thrombolytic therapy.[4] Patients who present with severe, prolonged chest pain but without ST elevation will be considered for thrombolytic therapy if left bundle branch block pattern is present or if there is evidence of a direct posterior MI. Otherwise, such patients are treated as having non-Q wave MI, given heparin for anticoagulation as well as aspirin and Tridil, and quickly moved to the CCU. If enzyme levels remain negative or the patient has refractory pain, immediate cardiac catheterization is considered to define the anatomy for doing percutaneous transluminal coronary angioplasty or coronary artery bypass grafting.

Moderate probability ischemia: Tracts III

Patients who present with classical angina (either new onset or worsening) but who quickly become stable in the ED, need to be evaluated for myocardial ischemia. An acute observation area allows critical care nurses to evaluate and reevaluate patients many times over the course of six to eight hours. Clues such as ventricular arrhythmia, hemodynamic changes, chest pain occurrence and response to nitroglycerin, and ST monitoring changes help to indicate if such patients belong in the high risk category (requiring management in the CCU with heparin, aspirin, and Tridil) or in the low risk category (requiring further observation and testing in a telemetry unit). Both sets of patients are usually admitted to the hospital and have an exercise stress thallium test or cardiac catheterization the next day. Some studies indicate that such focused activity reduces the length of hospital stay from five days to about one and a half days.[5]

Figure 2: Risk Stratification For Early Myocardial Ischemia CPED Management



Low probability ischemia: Tracts IV and V

Patients who present with atypical chest pain (nonspecific ECG changes) can be discharged from the ED after a certain amount of testing if the ED physician feels comfortable with the decision (**Figure 3**). In some cases, the history alone may provide enough information for the patient to be sent directly home. In most cases, however, additional tests are needed, which usually include accelerated enzymes (myoglo-

Figure 3. Tracts IV and V: degree of comfort for discharge

History alone ⇨ home

History + myoglobin ⇨ home

History + myoglobin + rest cardiolite ⇨ home

History + myoglobin + rest cardiolite ⇨ home
CPK-MB stress

History + myoglobin ⇨ chest pain next day,
CPK-MB with or without stress thalium

80% of patients go home
20% of patients are admitted

bin, troponin T, creatine phosphokinase-MB, a rest technetium sestamibi scan, or a stress test using the treadmill or Persantine technetium sestamibi. In some cases, the patient can be discharged early and scheduled for an exercise stress thallium test the next day as a completion of the workup.

In most cases, tracts I and II represent strategies for dealing with acute MI. Tract III represents a strategy for evaluating active myocardial ischemia. Tract IV allows ED physicians management flexibility with the option of involving a cardiologist in some cases. Tract IV as well as Tract V represent strategies for managing nonischemic pain.

Implications

Patient education. In addition to providing an opportunity to assess coronary disease through stress testing, the management workup described above allows an assessment of risk factors in patients who present to the CPED and an opportunity to educate them. This form of prevention and health promotion uses the chest pain experience as a "teachable moment" that may be useful in encouraging a transformation in lifestyle.

Monetary savings. Assuming that initial figures are correct and that 80% of patients with low-risk myocardial ischemia can be sent home,[6-8] ED management of chest pain may save a considerable number of health care dollars. In addition, community hospitals will be able to develop aggressive outreach messages that encourage patients with milder forms of heart attack to present early for screening. Thrombolytic therapy currently reaches only a small percentage of patients with MI and does little for those with prodromal symptoms of acute myocardial ischemia. Rapid ED scanning may allow community hospitals to focus on patients with early heart attack symptoms.[3,5,9]

Conclusion

The plan described above offers quality performance and cost reduction by combining general guidelines with critical pathways. It addresses continuous quality improvement issues as well as Medicare's critical indicators for myocardial infarction. The plan is a combination of the critical pathways now being used at St. Agnes Hospital in Baltimore, the University of Maryland Medical Center, and the Medical College of Virginia. In an effort to be more efficient and consistent, other chest pain centers are adopting the plan to manage chest pain patients in the ED.

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Residents' breast examination performance. How often? How well?

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ABSTRACT: *The American Cancer Society recommends annual clinical breast examination (CBE) for women with average risk of breast cancer beginning at age 40. The purpose of the current chart review study was to determine the adequacy of CBE performed by house officers in a community teaching hospital. A chart audit of 92 women aged 50 or older who were consecutively admitted to the medical service was used as a baseline measure of CBE documentation. Two subsequent series of 100 women each were evaluated. The first series, which also involved women admitted to the medical service, followed increased emphasis on the importance of CBE during twice daily conferences with supervisor staff. The second series involved women admitted to the obstetrics/gynecology service. In that series, house staff used two history/physical examination forms: one with a slot dedicated to CBE and one without a dedicated slot. Results indicate that supervisors' stressing the importance of CBE resulted in only slight improvement in house officers' performance, even in the presence of risk factors for breast cancer. In the third chart audit, CBE was documented by 88% of house staff who used a form with a dedicated slot for CBE; there were no CBE documentations among staff who used a form without a dedicated slot. The dedicated form was more successful in increasing CBE performance and documentation than verbal emphasis about the importance of breast cancer screening.*

Breast cancer is the most commonly diagnosed cancer and the second leading cause of deaths among American women.[1,2] The incidence of breast cancer in the United States in 1994 was estimated to be 182 000.[1] Several factors are known to predict the outcome of the disease, including

Figure 1. Questionnaire distributed to house staff

Note: Please answer the following questions as honestly as possible.
All answers will be kept strictly confidential.

1. Are routine breast exams done on all female patients more than 50 years of age?
   Always Usually Sometimes Seldom Never

   If not always, why not?

2. What risk factors do you look for in doing breast examination?

3. Are routine breast exams documented in the chart?
   Always Usually Sometimes Seldom Never

4. Are breast exams performed in the sitting position?
   Always Usually Sometimes Seldom Never

5. Are breast exams performed in the supine position?
   Always Usually Sometimes Seldom Never

the size of the tumor and the presence of axillary nodes. As a result, specific guidelines have been implemented to reduce mortality from the disease. The latest recommendations from the American Cancer Society include annual clinical breast examination (CBE) for women with average risk for breast cancer starting at age 40 and annual mammography beginning at age 50 as basic detection methods.[1] These recommendations are supported by the American College of Physicians, the Canadian Task Force on Periodic Health Examination, and the United States Preventive Services Task Force.[3,4]

There appears to be some hesitancy on the part of clinicians to implement these guidelines. Although the use of mammograms has been increasing, the use of CBE may be on the decline.[5] In a 1992 study involving women aged 50 and older, only 39.8% had both studies done as recommended and only 56.9% had a breast examination within the past year. In a 1980 study at a community teaching hospital involving 772 women aged 26 to 65, only 55% had a documented CBE; of these, the residents were responsible for documenting only 9%.[7]

The purpose of the current study was to determine the adequacy of CBE by house staff in a community teaching hospital.

Methods

Part 1. A chart audit was undertaken of 100 consecutive women aged 50 or older who were admitted to the medical service from July to December 1993. Eight patients were excluded because their charts could not be located in a timely fashion.

The admitting history and physical examinations are performed primarily by interns. No preprinted forms are used; interns write their findings freehand on lined paper. The notes were reviewed for actual documentation of breast examinations. The presence of risk factors for developing breast cancer, including previous history of benign breast lesions, previous history of cancer elsewhere, family history, nulliparity, estrogen use, and history of breast cancer in the opposite breast, were evaluated. χ^2 was used to determine if any of these factors significantly influenced the documentation of breast examinations.

Part 2. A questionnaire (**Figure 1**) was distributed to house staff to determine if breast examinations were performed routinely during admitting physical examinations of women aged 50 or older, in what position the examinations were performed, and if documentation was subsequently entered in the chart. The questionnaire also asked for reasons why breast examinations were not always done. The questionnaire was patterned after one used to determine practice patterns of obstetrician/gynecologists who attended the postgraduate course of the American College of Obstetricians and Gynecologists.[8]

Table 1. Documented breast examinations according to risk factors for breast cancer in the first chart audit

Documented Breast Exam (n = 92)	Risk Factors for Breast Cancer						
	Previous Breast Cancer	Family History of Breast Cancer	Benign Breast Lesions	Previous History of Cancer Elsewhere	White Race	Nulliparity	Use of Estrogen
+ (17)	0	1	1	5	13	0	0
- (75)	6	2	2	14	57	3	0

Table 2. Comparison of breast examination findings between the first and second chart audits

Clinical Findings	Audit 1 n = 17	Audit 2 n = 29
"no masses"	9	2
"no masses or discharge"	2	7
"no masses or tenderness"	1	0
"no masses, tenderness, or discharge"	2	13
"no masses, discharge or skin lesion"	1	1
"normal"	2	2
"atrophic"	0	1
"(+) skin lesions	0	2
"(+) nodules, ulceration, retraction"	0	1

Part 3. House staff and medical students were tested on how many masses they were able to palpate in each of two identical models. Palpating a total of five masses per model was considered a perfect score. Participants were divided into three groups: medical students, interns, and residents. Student's *T* test was used to determine if there was any significant difference in the detection of masses among the three groups.

Part 4. After data in Part 1 were analyzed, the chief resident and the program director of the department of internal medicine informed house staff several times about the need to improve performance and documentation of CBE. A second chart review was then undertaken of 100 consecutive women aged 50 or older who were admitted to the medical service from February to March 1994. Risk factors were again taken into consideration in the analysis of breast examination documentation and the data analyzed using the χ^2 test.

Part 5. A third chart review was undertaken of 100 consecutive women aged 50 or older who were admitted to the medical service from January to March 1994. Admitting history and physical examinations were reviewed as previously described. It was noted that obstetrics/gynecology residents used two different forms to document their histories and physical examinations. One form included a dedicated slot for breast examination; the other did not.

Results

Parts 1 and 4. In the first chart audit, only 17 of the 92 patients (18%) had a documented breast examination. Of the 17 patients, 9 were reported to have no masses. Examination for axillary nodes was noted for only two patients. No breast or axillary examination was recorded for the six patients who had a previous history of breast cancer. The presence of other risk factors for breast cancer did not seem to influence performance of breast examination (**Table 1**).

After house staff was notified of the above initial results and encouraged to perform and document breast examinations, the subsequent chart audit showed that 29 of 100 patients (29%) had a documented breast examination (**Table 2**). Of the 7 patients with a previous history of breast cancer, however, only 2 were given breast examinations and 1 was examined for axillary nodes (**Table 3**).

Part 2. From the questionnaire, 50% of the residents reported doing breast examinations sometimes, but seldom documenting them (**Table 4**). Common reasons given for not always examining the breasts were that breast examination was overlooked or missed or that the patient refused it. Thirty-five percent of residents said they performed breast examinations with patients in the sitting position and 35% said examinations were performed with patients in the supine position.

Part 3. There were no significant differences in the number of breast masses palpated on both breast models among medical students, interns, and residents. Although interns had the lowest score, the difference was not statistically significant (**Table 5**).

Part 5. Of 100 patients from the obstetrics/gynecology service, 37 (37%) had documented breast examinations (**Table 6**). Of two patients with a previous history of breast cancer, only one had a documented breast examination. Forty-one percent of the house staff used the hospital admitting history and physical examination form that had a slot for breast examination findings, and 58% used the form that did

Table 3. Documented breast examinations according to risk factors for breast cancer in the second chart audit

Documented Breast Exam (n = 100)	Risk Factors for Breast Cancer						
	Previous Breast Cancer	Family History of Breast Cancer	Benign Breast Lesions	Previous History of Cancer Elsewhere	White Race	Nulliparity	Use of Estrogen
+ (29)	2	1	3	5	29	0	3
- (71)	5	4	8	14	55	0	1

Table 4. Questionnaire results

QUESTIONS	ANSWERS				
	Always	Usually	Sometimes	Seldom	Never
Are CBE done on female patients more than 50 years old?	3 (15%)	5 (25%)	10 (50%)	2 (10%)	0 (0%)
Are CBE documented in the chart?	2 (10%)	5 (25%)	6 (30%)	7 (35%)	0 (0%)
Are CBE performed in the sitting position?	2 (10%)	4 (20%)	5 (25%)	7 (35%)	2 (10%)
Are CBE performed in the supine position?	5 (25%)	7 (35%)	2 (10%)	5 (25%)	1 (5%)

not have a dedicated slot. One house staff member used a blank sheet. Of those who used the form with a slot for breast examination results, 88% documented breast examinations. By contrast, none of those who used the form without a dedicated slot documented breast examinations. The staff member who used a blank sheet of paper reported unremarkable breast findings.

Discussion

Screening for breast cancer reduces the mortality in women aged 50 and older.[9] Controlled trials have shown that screening annually for 10 years with breast physical examination decreases the number of deaths from breast cancer by approximately 25 per 10 000 women at ages 40, 50, and 65 years. Adding annual mammography decreases the number of deaths by an additional 25 per 10 000 women.[9] One of the most common claims among malpractice litigations involving 34 cases of breast cancer patients in New York state from 1985 to 1991 was that the physician failed to examine properly and palpate the breasts and detect a palpable lesion.[10] Moreover, studies suggest that younger internists and residents are less inclined to do CBE, order mammograms, and perform Pap smears.[7,11]

Table 5. Average number of masses palpated on 2 breast models (maximum score of 5 possible for each model)

	Model 1	Model 2
Medical students (n = 9)	4.1	4.0
Interns (n = 13)	3.8	3.8
Residents (n = 7)	4.0	4.3

In the current study, only 17% of women aged 50 or older who were admitted to an acute care teaching hospital had a documented CBE, a finding comparable to the 9% CBE documentation rate by house staff in another teaching hospital.[7] A most disturbing finding was that the presence of risk factors for breast cancer did not influence house officers' performance and documentation of CBE. Even after repeated emphasis on its importance, there was only slight improvement.

From the questionnaire, only 15% of the house staff claimed to always do an admission CBE on women aged 50 or older. Only 10% documented the results in the charts. No good reasons were identified for failure to perform and document breast examinations.

On palpation for masses in breast models, there was no significant difference in the number of masses palpated by house staff and medical students. Both groups performed adequately. However, the examination was done in an artificial setting where attention is focused on an inanimate object. Having less experience in the examination of living patients, house staff and students could be affected by such factors as discomfort, lack of confidence, or distractibility, which could influence the accuracy of palpation for masses.

Table 6. Documented breast examinations according to risk factors for breast cancer in the chart audit of patients admitted to the obstetrics/gynecology service

Documented Breast Exam (n = 100)	Risk Factors for Breast Cancer						
	Previous Breast Cancer	Family History of Breast Cancer	Benign Breast Lesions	Previous History of Cancer Elsewhere	White Race	Nulliparity	Use of Estrogen
+ (37)	1	3	6	6	32	0	6
- (63)	1	0	4	13	60	0	16

On the third chart audit, there was 88% CBE documentation by obstetrics/gynecology house staff who used examination forms with dedicated slots for CBE. Compared to the 0% documentation rate among similar residents who used a form without a dedicated slot, the difference is impressive. Thus, a reminder system seemed to play a role in outcome. The dedicated slot on the form was more successful in increasing the rate of documentation of CBE than emphasis during residency training about the importance of screening for breast cancer.

A number of measures to increase CBE documentation are in the process of development at our teaching hospital. In addition to the dedicated slot for documenting CBE on the examination form, these include repeated emphasis on performing CBE, including CBE as part of the orientation process for new house staff and interns, instituting a CBE training program, and having house staff rotate through a breast clinic as part of the training experience. Such methods could also be used to increase the documentation of rectal and pelvic examinations and other important parts of the physical examination.

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INTERIM STUDIES REQUIRED BY 1995 MARYLAND HEALTH CARE LEGISLATION

Patient Access Act (SB 449 & HB 724)

- The secretary of the Department of Health and Mental Hygiene, the deans of the University of Maryland and Johns Hopkins medical schools, and the president of Monumental City Medical Society are to conduct a study to determine if there is a need in Maryland to require all health care practitioners to participate in the Maryland Medical Assistance Program as a condition of licensure and certification. A report is due to the Senate Finance Committee and the House Economic Matters Committee by December 15, 1995.
- The Governor's Task Force on Community Health Networks is to conduct a study to determine what further regulation is needed to ensure that health care delivery networks remain responsive to their communities, are "broadly representative" of the health provider community, and maintain necessary capitalization reserve requirements. A report is due to the governor and General Assembly by December 15, 1995.

Health Care Reform Act of 1995 (SB 639)

- The Department of Fiscal Services in consultation with the Health Services Cost Review Commission is to conduct two studies: one is to examine methods of financing uncompensated care through freestanding ambulatory facilities and other health care delivery systems; the other is to assess the current method for financing graduate medical education in hospital rates and recommend a plan for equitable distribution of reasonable costs of such education in hospital and nonhospital settings. Reports on both studies are due to the Senate Finance Committee and the House Economic and Environmental Matters Committee by December 1, 1995.
- A task force is to study access to obstetricians/gynecologists, including the effect that a primary care physician has on a woman's obtaining appropriate gynecological care. A report is due to the governor and General Assembly by October 15, 1995.

Solid and papillary epithelial neoplasm diagnosis and treatment: a case study

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The solid and papillary epithelial neoplasm, also known as solid-cystic neoplasm, is a rare pancreatic tumor (less than 100 cases reported). It usually occurs in younger women, particularly black women.[1-6] It occurs at an earlier age than adenocarcinoma of the pancreas, but has a favorable prognosis with appropriate surgical treatment. We present our recent experience with a patient with this diagnosis.

Case presentation

A 44-year-old black woman was referred with a pancreatic mass. She had a nine-month history of right upper quadrant abdominal and epigastric discomfort with occasional nausea. At the referring hospital, an ultrasound study ruled out cholelithiasis and revealed a pancreatic mass. Endoscopic retrograde cholangiopancreatography revealed obstruction of the main pancreatic duct at the level of the head of the pancreas. Fine needle aspiration guided by computed tomography (CT) revealed numerous papillary groups of nonmucinous cells consistent with solid and papillary epithelial neoplasm of the pancreas, but did not rule out microcystic adenoma and neuroendocrine tumor.

Evaluation at our institution showed no significant past medical or surgical history. The patient's vital signs were stable and the physical examination was unremarkable. She had some epigastric discomfort. Laboratory studies, including a chemistry 20 profile, complete blood count, prothrombin time, amylase, lipase, and carcinoma antigen 19-9, were within normal limits except for a white blood cell count of 11.4 and an erythrocyte sedimentation rate of 35 mm/hr. X-ray film of the chest was normal.

A CT scan revealed a heterogeneously enhancing, well-circumscribed mass measuring 11 by 9 by 8 cm in the midabdomen arising from the body and tail of the pancreas. It did not appear to involve the head of the pancreas. Areas of calcification and necrosis were scattered throughout.

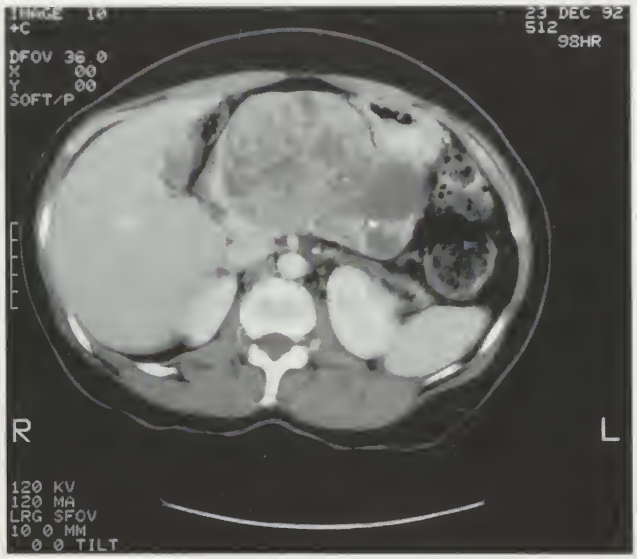


Figure 1. CT scan with circumscribed heterogeneous mass involving head, body, and tail of pancreas. Uncinate process and part of pancreas head appear clean. Multiple areas of calcification and necrosis are scattered throughout.

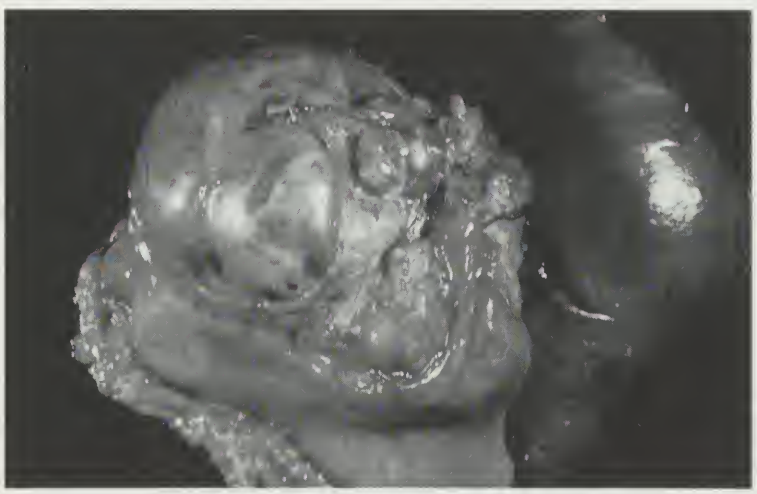


Figure 2. En bloc resection of tumor with spleen and distal stomach.

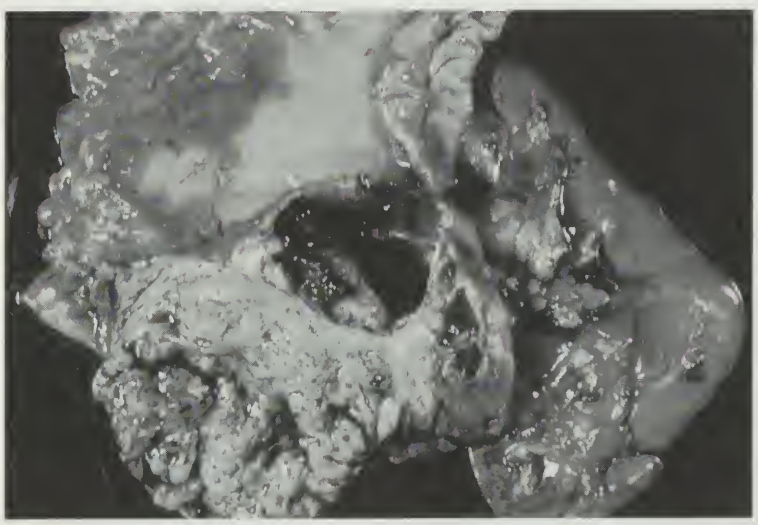


Figure 3. Sectioned surface of the tumor. There were rough, solid-tan cysts; tan regions; papillary areas; numerous cysts; and zones of hemorrhage and necrosis.

There was no evidence of vascular involvement or metastasis (**Figure 1**). Exploration revealed an encapsulated mass measuring 14 cm that involved part of the head, body, and tail of the pancreas and displaced the stomach laterally (**Figure 2**). It was attached to the lesser curvature extending to the pylorus. The remainder of the abdomen was free of metastasis.

En bloc subtotal pancreatectomy, distal gastrectomy, proximal duodenectomy, and splenectomy were performed. A cholangiogram showed good flow into the duodenum with a normal biliary tree. The sectioned surface of the tumor had a variable appearance with soft solid tan regions, papillary areas, numerous cysts, and zones of hemorrhage and necrosis (**Figure 3**). The tumor did not invade adjacent structures.

Microscopic examination showed polygonal cells in several patterns including solid, papillary, acinar, and cystic. Foamy macrophages were interspersed in some solid foci, presumably in response to degenerative changes in the vascular watershed (**Figure 4**). Papillary portions were supported by delicate and sometimes edematous fibrovascular cores (**Figure 5**). Cysts were lined by similar cells and many contained fibrin and degenerating blood. Nuclei were ovoid with frequent clefting and longitudinal grooves. Mitoses were not a feature. There were occasional groups of cells with intracytoplasmic hyalin globules (**Figure 6**). Immunocytochemical stains were positive for alpha 1-antitrypsin, neuron specific enolase, and keratin.[7-9]

The patient did well postoperatively; her blood glucose remained stable without insulin and she was discharged on postoperative day seven tolerating a post-gastrectomy diet. At a follow-up of 27 months, she is free of disease, asymptomatic, and working as a school teacher.

Discussion

The solid and papillary epithelial neoplasm of the pancreas is a rare tumor that ranges in any combination of solid, papillary, and cystic forms. It is composed of clear to eosinophilic polygonal cells, rare mitoses with occasional intracytoplasmatic periodic acid-Schiff-positive globules.[1,7]

Foamy macrophages can be seen in areas away from the fibrovascular papillary cores.[1] Fine needle aspiration smears of the lesions are usually cellular and composed of uniform cells that cling to arborizing fibrovascular cores forming papillary fragments.[10-15] The tumor cells are cuboidal to columnar with bland ovoid nuclei characterized by finely

granular chromatin and small nucleoli. On both histologic and cytopathologic examinations, the lesion can be confused morphologically with an islet cell tumor, which may have similar cytologic features and may also undergo cystic transformation. Islet cell tumors, however, generally do not show the papillary features seen with solid and papillary epithelial neoplasm.[12,15,16] Microcystic adenoma, which was also in the differential diagnosis in our case, is also composed of bland cuboidal cells, but generally presents in older patients and lacks papillary structures with fibrovascular cores on fine needle aspiration. Positive staining for alpha 1-antitrypsin, keratin, and neuron-specific enolase have been previously reported.[9,10]

Due in part to the variable staining patterns that have been observed to a variety of antibodies, the proposed origin of the tumor has included pancreatic acinar cells, ductal cells, islet cells, and primitive multidirectional pancreatic cells.[9,13,17] Because of the tumor's incidence in young women, the role of hormones has been of interest, and in some cases tumors have been evaluated for the presence of estrogen and/or progesterone receptors, with variable results.[10,13,18]

Our patient was referred with a typical presentation of solid and papillary epithelial neoplasm. The tumor is found when the patient is evaluated for increasing abdominal discomfort or an enlarging mass, or as an incidental finding.[3,4] The overall health of the patients and laboratory studies usually are unremarkable.[2,3,5] In the current case, a CT scan and fine needle aspiration allowed a more definite diagnosis and was instrumental in planning the surgery. CT scans reveal a heterogeneous, well-circumscribed mass with hemorrhagic necrosis and rare calcifications[19,20] which, along with the clinical picture seen in younger women, can be highly suggestive of the diagnosis.[8] The only reported CT finding with metastases shows them to be similar to the primary tumor.

Accurate preoperative diagnosis rests on the combination of clinical presentation, radiographic findings, and fine needle aspira-

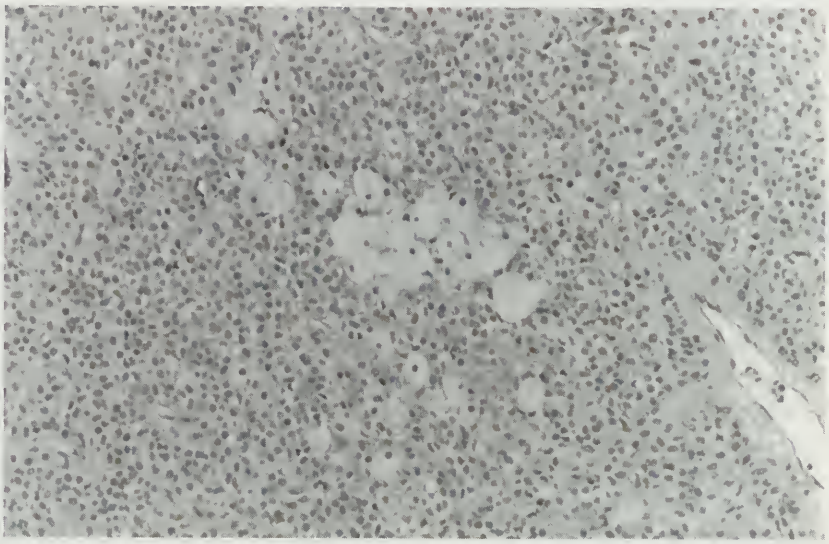


Figure 4. Micrograph showing interspersed, foamy macrophages in some areas.

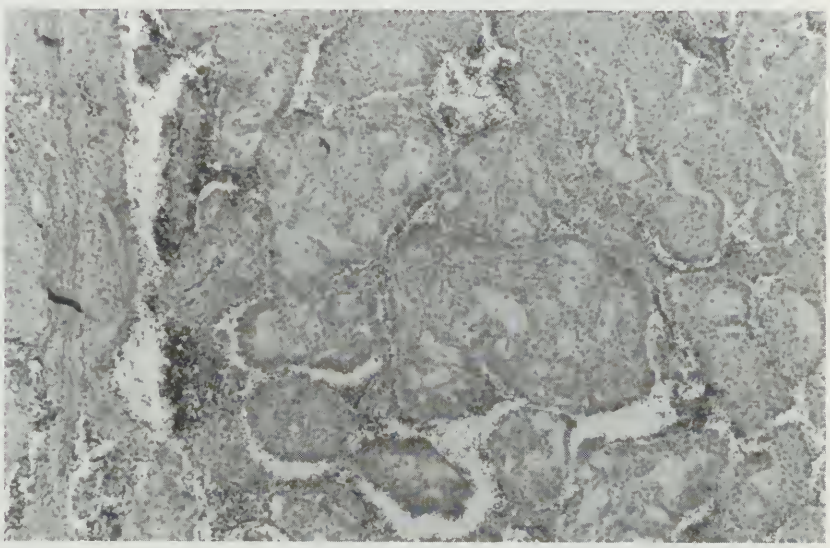


Figure 5. Micrograph showing papillary portions supported by delicate and sometimes edematous fibrovascular cores.

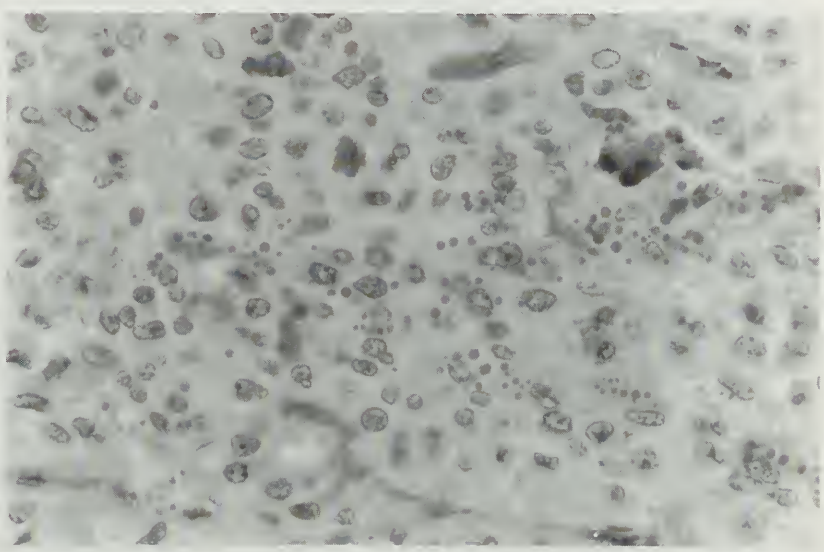


Figure 6. Micrograph showing groups of cells with intracytoplasmic hyalin globules.

tion cytology. Fine needle aspiration can be helpful in suggesting the correct diagnosis and directing appropriate patient management.[11-13] Complete surgical resection of these large tumors (10-15 cm) is the treatment of choice. Metastasis or recurrence is uncommon following complete resection.[4-6,8] Morohoshi and colleagues[7] state that these tumors "are almost invariably benign", but it may be more appropriate to say that their potential for malignancy is very low.

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LATEX ALLERGY TEST

The U.S. Food and Drug Administration has approved a laboratory test, the DPC AlaSTAT, that measures immunoglobulin E antibodies specific to latex. The American Academy of Allergy and Immunology recommends testing for health care workers; latex industry workers; children with spina bifida; people who have had multiple surgeries; and people who experience anaphylaxis or oral itching after eating avocados, bananas, kiwi, or chestnuts. The FDA has received more than 1000 reports of allergic reactions to latex and has confirmed at least 15 deaths due it. For more information about the allergy test, contact the manufacturer, Diagnostic Products Corporation (800-678-6699, ext 2088; fax 213-776-0204).

Geriatrics for the Clinician

URINARY TRACT INFECTIONS IN THE ELDERLY

The elderly are prone to a variety of infectious diseases. The accumulation of years of environmental insults, changes in various organ systems due to aging, and changes due to aging in the immune system itself are all factors that play a role in the increased incidence of infectious diseases in the elderly. The most common serious infection in this age group is urinary tract infection (UTI). This review emphasizes how the elderly differ from younger patients with respect to the presentation, diagnosis, and treatment of UTIs.

Changes of aging that affect susceptibility to UTI

Many changes in host defenses, as well as dysfunction of the immune system itself, affect elderly persons' susceptibility to infection.[1] In the case of UTIs, incomplete emptying of the bladder and the production of less acid urine contribute to increased susceptibility.

Elderly persons suffering from infectious diseases, including those who have developed a UTI, often present atypically. Although an elderly person might present with dysuria, frequency, and urgency, changes in function, such as falls, delirium, poor appetite, and incontinence, may be the only clues to early infection. Ill elderly often underreport symptoms, and complaints arising from chronic disease may mask other symptoms.[2] Even those with serious infections such as sepsis syndrome may be afebrile.[3] When fever is present, however, elderly patients are more likely than younger patients to have a life-threatening infection.

Diagnosis and treatment

UTIs are the most common bacterial infections in the elderly. Among non-institutionalized elderly, about 5% to 15% of elderly men and 10% to 30% of elderly women experience UTIs. Urinary tract infections occur much more frequently in elderly patients who are functionally impaired, such as those in nursing homes and those with indwelling or condom catheters.

The presentation of UTI infection may range from minor suprapubic discomfort to the classic symptoms of dysuria, urinary frequency, and urgency, to fever and hypotension from sepsis syndrome. Elderly patients with pyelonephritis may have gastrointestinal symptoms, such as diarrhea, or respiratory symptoms, such as shortness of breath.

Asymptomatic bacteriuria—the presence of bacteria in the urine in patients without any symptoms—has been associated with increased mortality. Additional studies have shown, however, that treatment of these patients does not improve their prognosis and exposes them to the adverse effects of antibiotic therapy, such as antibiotic-associated colitis. Most authorities recommend against treatment of these patients except under certain circumstances (e.g., obstructive uropathy, recurrent symptomatic UTIs).[4]

Escherichia coli accounts for the majority of UTIs in both elderly men and women. UTIs in institutionalized elderly patients, however, are often caused by other, frequently antibiotic-resistant Gram-negative bacilli such as *Klebsiella* species, *Proteus* species, *Enterobacter*, or other Enterobacteriaceae.[5]

As in younger patients, laboratory assessment begins with urinalysis and urine culture. Pyuria in a centrifuged specimen (greater than four leukocytes per high-power field under the light microscope) is a sensitive test for UTI, but its absence does not exclude infection. A urine culture that grows 10^5 pathogenic bacteria/ml remains diagnostic of UTI in a symptomatic elderly patient. Lesser counts might also indicate infection that merits antibiotic treatment. Because antibiotic-resistant bacteria are more common in both the institutionalized elderly and those who reside in the community, a urine culture should be obtained whenever possible.

Other diagnostic studies might be helpful under certain circumstances. Multiple blood cultures are

indicated in patients with pyelonephritis or sepsis syndrome. Imaging studies such as ultrasonography should be considered for patients who remain febrile for more than 96 hours, who may have obstruction, who are bacteremic, or who have persistent bacteriuria.[6] Antibiotic treatment for UTI depends on the severity of infection and the presumed site of infection (kidney or bladder).[6] Patients with minor or no systemic signs or symptoms are treated with oral antibiotic therapy. Those with sepsis syndrome or pyelonephritis are hospitalized for parenteral antibiotics, intravenous fluids, and other supportive treatment. Antibiotics usually appropriate for outpatients without catheters or abnormalities of the urinary tract include amoxicillin, trimethoprim-sulfamethoxazole, norfloxacin, and first- or second-generation cephalosporins. Treatment may be started before culture results are available, but antibiotic therapy should be reviewed as soon as results are ready.

Broad-spectrum antibiotic treatment is usually given for seriously ill elderly patients, such as those with sepsis syndrome or difficult-to-eradicate infections (e.g., in those with indwelling bladder catheters). Appropriate parenteral antibiotic therapy may be ampicillin or a first-generation cephalosporin combined with an aminoglycoside, a third-generation cephalosporin, ampicillin/sulbactam, imipenem/cilastatin, or a fluoroquinolone. When aminoglycosides are relatively contraindicated (e.g., in patients with dehydration or chronic renal failure), aztreonam may be substituted. Elderly patients with less serious systemic illness and who do not have a history of an indwelling catheter may be treated with intravenous trimethoprim/sulfamethoxazole, a first- or second-generation cephalosporin, or ciprofloxacin. The duration of therapy should be guided by the severity of illness, but both outpatients and inpatients usually should receive at least seven to ten days of appropriate antibiotic therapy. Elderly men with chronic bacterial prostatitis may require four weeks of fluoroquinolone or three months of trimethoprim/sulfamethoxazole antibiotic therapy.

Conclusion

In the elderly, UTI presentation may be subtle. Elderly individuals with a UTI are more likely to be infected with antibiotic-resistant Gram-negative aerobic bacteria, especially if they have recently been hospitalized or live in a long-term care facility. Therapy with a broad-spectrum antibiotic is usually given until the results of the urine culture (which should always be obtained) are available. Prolonged therapy is warranted for severely ill patients or men with prostatitis.

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"The basic justification for compassion is simply decency, not economics."

Redelmeier DA, Molin J-P, Tibshirani RJ. A randomised trial of compassionate care for the homeless in an emergency department. *Lancet* 1995;345:1131-1134.

Aesculapius at the bicentennial: reflections on the evolution of the insignia of the Medical and Chirurgical Faculty of Maryland

Aesculapius, a name familiar to physicians, is generally understood to be the Greco-Roman god of medicine. Great temples were erected to venerate this son of mighty Apollo who was revered as a skillful healer, honored as a hero, and ultimately worshipped as a god.

Through the ages, the mythical figure of Aesculapius has been used to symbolize the practice of medicine. Clad in sandals and a long robe, he is usually represented as a hoary figure with a contemplative mien, bearing his customary serpent-entwined staff. Except for these standard attributes, however, no prototypical image exists. Nevertheless, the imaginations of artists have provided us with countless interpretations of the romanticized healer. Over the past two centuries in the State of Maryland, we have had an especially rich experience with Aesculapian symbolism.

The Medical and Chirurgical Faculty of Maryland was granted a charter by the state legislature on January 20, 1799. The act included authorization for a seal that could be used as an imprimatur on certificates of licensure granted by the medical board. According to Faculty records, the seal was first made available on June 23, 1799. The original designer is unknown. The design portrays a seated, robed Aesculapius, his left foot propped on a brick-like structure (**Figure 1**). His right hand rests on a vertically oriented, untitled book that in turn rests on a stack of five volumes, each entitled with a scientific discipline. His left hand grasps a staff around which no serpent coils. His forward-facing, bearded and bald head contains dark, deep-set eyes. A halo of radiating lines surrounds the head, the shape of which earned for the seal the title "Old Potato-head." Around the perimeter of the seal, in Latin, is the equivalent of *Medical and Chirurgical Society of Maryland Seal Month of June 1799 A.D. 23rd year of the Institution of American Liberty*. Under the seated figure there is a quotation in

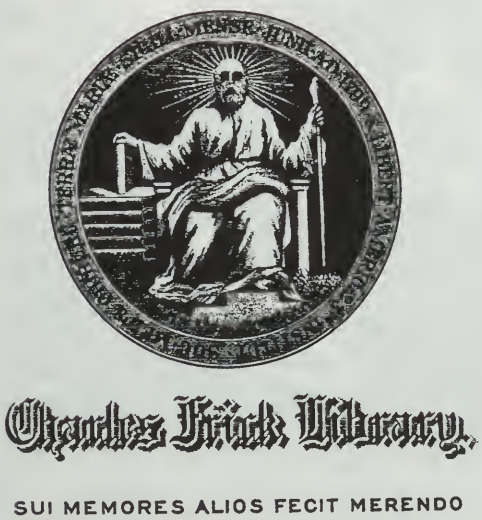


Figure 1. The original seal of the Medical and Chirurgical Faculty of Maryland.



Figure 2. Seal on the frontispiece of *The Medical Annals of Maryland.*



Figure 3. Bronze medal designed by Max Brödel to commemorate the dedication in 1909 of the new Med Chi building on Cathedral Street in Baltimore.

classical Greek from the eleventh book of Homer's *Iliad.* Broadly translated, it reads, "A physician or a surgeon is of more value than many other men for the dressing of wounds and the stilling of pain." This version of the seal, which remained unchanged for 131 years, can currently be found as a steel engraving on old Faculty documents and book plates and impressed in wax on several well-preserved, early nineteenth century state medical licenses.

The Medical Annals of Maryland was published by Eugene Fauntleroy Cordell, M.D., in 1903 to commemorate the centennial of the Faculty. On the frontispiece of the monumental volume there appeared a somewhat altered seal (**Figure 2**), in which "Potato-head" was endowed with a full head of hair and greatly enhanced halo. Also a steel engraving, the interpretation seems to be unique to Cordell's opus. The originator remains unknown.

The year 1909 was highlighted by a very special event: the Faculty opened and dedicated a new building on Cathedral Street in Baltimore. The occasion, which attracted medical luminaries from around the country, was commemorated by the issuance of a bronze medal (**Figure 3**) designed by Max Brödel, the preeminent medical illustrator in residence at Johns Hopkins. The obverse side of the medallion displays a robed, seated, studious old gentleman. Once again, he is bald. He faces to the left and looks downward while reading one of a half dozen books that surround him. Two volumes lie askew on a table adorned by an encircled, five-point star in the center of which is a tiny staff of Aesculapius. His feet are on a level surface and his right hand casually grasps a thin staff bearing a loosely coiled serpent. The throne-like chair in which he is seated is decorated with a Greek key design. In the background is a portion of a Greek temple. A burst of sunlight from behind creates a dramatic effect.

Was Aesculapius given a new look or did Mr. Brödel intend the figure to be Hippocrates, an historically real physician? There is a tree in the distant background; perhaps it is the one under which the father of medicine sat while teaching on the island of Cos. Brödel, the father of medical illustration, left no record of his intentions, but the Faculty expressed its

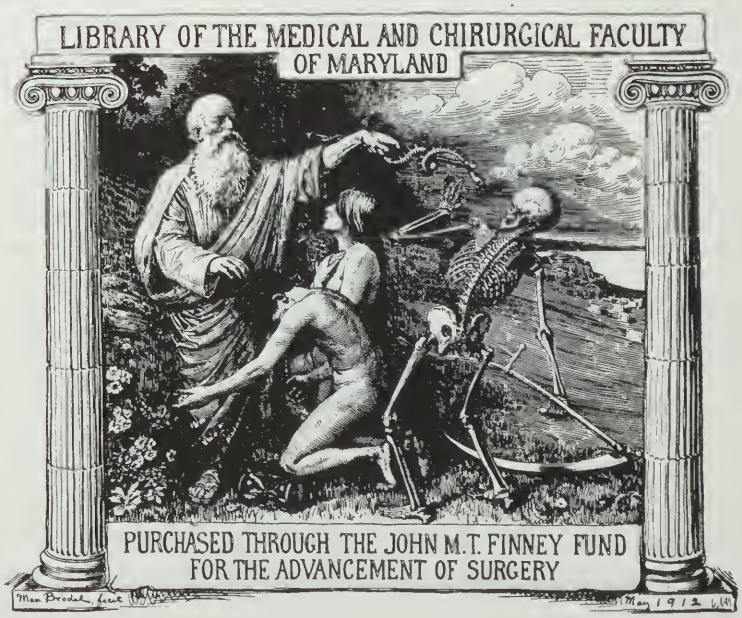


Figure 4. Brödel bookplate designed for the John M.T. Finney Fund for the Advancement of Surgery.



Figure 5. Brödel bookplate designed for the William Osler Testimonial Fund for the Advancement of Medicine.

appreciation by unanimously electing him an honorary member.

In the years that followed, Brödel applied his enormous talents to the design of four bookplates for the Faculty library. Each was meant to identify books purchased through the generosity of named endowments. Each was a masterpiece filled with symbolism. The first was designed for the John M.T. Finney Fund for the Advancement of Surgery (**Figure 4**). Central to the group of figures is an elderly, bald, bearded man wearing a sleeved shirt over which is a robe with key design at the hem. An overturned hourglass and two supplicant figures are at the feet of the omnipotent Aesculapius who, with a wave of his staff and its hissing snake, repels the grim reaper. The elaborate pattern on the skin of the snake might well have been suggested by Howard Kelly, equally renowned



Figure 6. Current Med Chi seal, redesigned by Brödel in 1930.

as a gynecologist and herpetologist and a friend and patron of Brödel.

In 1919, the William Osler Testimonial Fund for the Advancement of Medicine was honored with a Brödel bookplate (**Figure 5**). In it, action gives way to contemplation as a pensive Aesculapius with receding hairline forsakes his staff and with his left hand elevates the pulse of a young patient succored by a gentle Hygeia. An upturned shirt collar and a well-muscled forearm suggest more than just an inner strength.

The centennial of the Faculty library was celebrated in 1930 with a commemorative exhibit, an anniversary volume, and a redesign of the seal by Mr. Brödel to be used initially on a bookplate (**Figure 6**). That year, the emblem as we presently recognize it replaced "Potato-head." The hero is definitely more hirsute, and he appears more aged than in past renditions. His long robe is thrown into many folds, and while he reads he holds his staff between his knees. He is surrounded by his books and the other familiar symbols. Then-president of the Faculty Henry M. Fitzhugh, M.D., declared at the time of the celebration:

Perhaps, however, the outstanding contribution to this centennial is the new seal which has been designed to commemorate this occasion. It is the only work of genius, I might say, which this event has brought forth. Mr. Max Brödel, as associate member of our Faculty, has, out of the kindness of his heart and the wealth of his genius drawn this adaptation of our seal for a new book plate, and at this time we would like to call upon the members of the Faculty here present to give a rising vote of thanks to Mr. Brödel for his enduring contributions to the dignity and honorable traditions of our Library.

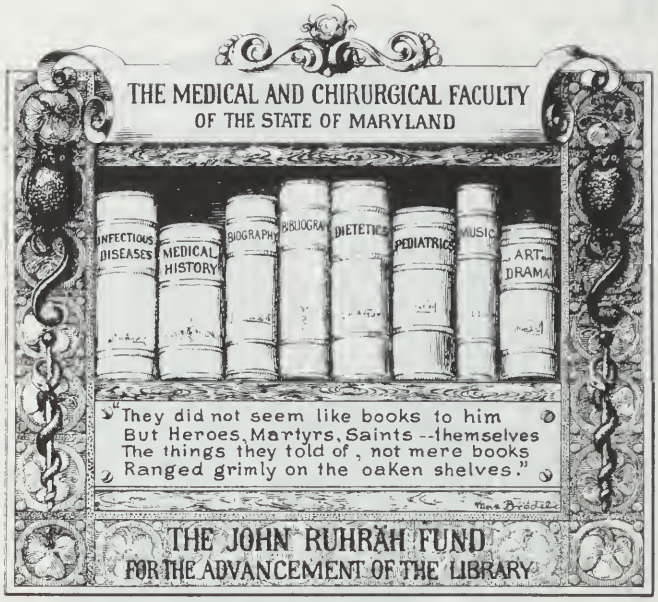


Figure 7. Brödel bookplate designed for the John Rührah fund.

The fourth Brödel-designed bookplate celebrates the fund established to honor the great pediatrician, bibliophile, and author, John Rührah. No Aesculapian figure, however, is included in the design (**Figure 7**).

As we approach the bicentennial of the Medical and Chirurgical Faculty of Maryland, we may look back with pride on the wisdom and compassion of our predecessors and the accomplishments of our medical society. The principles of Aesculapius have been well served.

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Dr. Fishbein, a general surgeon and associate professor of surgery at The Johns Hopkins University School of Medicine, is chairperson of Med Chi's Council on Scientific Affairs, Bicentennial Ad Hoc Committee, and Library and History Committee. Ms. Burri is the administrator/archivist of the Med Chi library. Ms. Crosby is an associate professor and director emerita of the department of art as applied to medicine at The Johns Hopkins University School of Medicine. ■

INTERNAL MEDIZZZZZZZ

Among Parkinson's disease patients, sleep disturbances are common and often difficult to treat adequately. Louis and Lynch[1] describe the case of an 80-year-old retired surgeon with Parkinson's disease who claimed to have no trouble sleeping *now*. When asked, he attributed his current success to "these tapes." Queried further, he said they were lecture tapes on internal medicine, to which he had been listening at bedtime. He added, "I'm thinking of getting the neurology series next."

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A Brief History of Women and Organized Medicine

Each September, the American Medical Association sponsors Women in Medicine Month to recognize and celebrate the growing number and contributions of women physicians. The AMA's recognition of Women in Medicine Month is a welcome change from the position espoused in 1871 by then-president Alfred Stillé, M.D. When approached by a group of women requesting admission to the AMA, Dr. Stillé acknowledged their right to study and practice medicine, but voiced serious doubts as to their ability to achieve eminence.[1] M.R. Walsh notes that during the late nineteenth century, "Within the medical establishment, many opposed the advancement of women, some tolerated it, but few members of the medical establishment advocated the cause with enthusiasm. Most male physicians simply reflected the prejudices of a larger society."[2]

Although the recognition of women's ongoing contributions to medicine is relatively new, their presence in the medical field is not. Four of the earliest known women physicians were Harriot K. Hunt and her sister, Sarah; Elizabeth Blackwell; and Lydia F. Fowler.[3] Harriot and Sarah Hunt set up practice in Boston in 1835. Sarah left, but Harriet maintained the practice until 1860, despite open ridicule by the established medical community.[1] Elizabeth Blackwell received initial medical training under Samuel Henry Dickinson, M.D., at Philadelphia's Blockley Hospital. In 1847, she was admitted to Geneva Medical School, Geneva, New York. Ms. Blackwell graduated in 1849.[4] Lydia F. Fowler attended the Central Medical College in upstate New York. Of three women admitted to the college in 1849, Ms. Fowler was the only one to receive her diploma.[5]

The acceptance of women into organized medicine came slowly. Med Chi was one of the first medical societies in the United States to admit women to their ranks. An amendment to the constitution proposed by then-chairman of the Section on Surgery, J. Edwin Michael, M.D., was passed in 1885.[6] In 1886, Med Chi welcomed its first woman member, Amanda Taylor Norris, M.D. In addition to being Med Chi's first woman member, Dr. Norris was the first degreed woman physician to practice in Baltimore. Female membership in Med Chi preceded female membership in the AMA by almost 30 years, admission to The Johns Hopkins University by 7 years, and admission to the University of Maryland by more than 35 years.

Since the 1960s, the number of women physicians has grown phenomenally. Until the 1960s, "women accounted for only about 5 percent to 6 percent of admissions to most coeducational medical schools throughout the country."[1] In the 1980s, approximately 25% of all medical students were women. In 1993-94, 40% of all medical students were women, and they were in the majority at nine schools.[7] Harvard, Yale, and The Johns Hopkins universities are currently reporting first-year female enrollments exceeding 50%.[8] Despite this recent surge in enrollment in medical schools, only 19% of all U.S. physicians are women. It is projected that by the year 2010, 30% of all physicians will be women.[7]

The AMA notes that of all women physicians choosing a medical specialty, 67% fall into one of seven specialties. In decreasing order of preference, these specialties are internal medicine, pediatrics, general/family practice, psychiatry, obstetrics and gynecology, anesthesiology, and pathology.[7]

Specialties chosen by women physicians in Med Chi still shadow those reported by Jensen in 1983.[3] Pediatrics, obstetrics and gynecology, family practice, psychiatry, and internal medicine remain heavy favorites. The percentage of women Med Chi members who chose internal medicine, family practice, and obstetrics remains relatively unchanged. The specialty that has seen the largest increase of practitioners among women members over the past few years is psychiatry. Specialties chosen by women still tend to center around women and children or require skills once considered a detriment to a women's success in the medical profession.

Unfortunately, the number of women in organized medicine, particularly in leadership positions, has not grown in proportion to the number of women physicians. Women represent only 12% of the current AMA member base; 13% of Med Chi. The AMA notes that "in the ten-year period between 1983 to 1993, the number of female delegates increased from 1.8% to 6.7%; alternate delegates from 3.0% to 11.5%; council members from 0% to 2.2%; and board members from 0% to 11.5%. Nevertheless...there is an underrepresentation of female physicians in AMA leadership bodies relative to the demographics of the physician and AMA populations."[7] As the number of women physicians continues to grow, it is critical that organized medicine seek ways to encourage participation and leadership from women. The celebration of Women in Medicine Month is a beginning.

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The wealth of online medical information that is now available to physicians also is available to patients. A breast cancer patient learned through the Oncolink database that tamoxifen may be associated with ophthalmologic problems. Not having received the information from her oncologists, she downloaded the article, printed it, and took it to her ophthalmologist with instructions that she be monitored in the future for potential tamoxifen side effects.

Source: Gratefully Yours, March/April 1995. Bethesda, MD: National Library of Medicine.

Books, Etc.

Aesthetic Blepharoplasty. Francis G. Wolfort, M.D., and William R. Kanter, M.D. Boston, MA: Little, Brown and Company; 1994. 226 pages. $185 (hardcover).

The authors have produced a very worthwhile text that should be of great value to both practicing plastic surgeons and to residents. Dr. Wolfort is an associate professor of surgery (plastic) at Harvard Medical School and surgeon and program director of the division of plastic surgery at New England Deaconess Hospital in Boston. Dr. Kanter is an instructor in plastic surgery at The Johns Hopkins School of Medicine and an attending staff member at St. Agnes Hospital in Baltimore. The book is well laid out, well organized, and easy to read, with a good mix of excellent, easily understood black and white, as well as color illustrations. The photographs in some cases are not of the same high quality as the illustrations and text.

This is a well-written, up-to-date book. I particularly like the chapters on aesthetic goals, and Pearls and Pitfalls (how to avoid and manage complications). It does not address the recent interest in laser resurfacing of the lower lid and crow's-feet ablation, which have become popular topics since the book went to press. For the most part, the book is very practical and readable; I highly recommend it.

BERNARD M. MCGIBBON, M.D., F.A.C.S.
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The Second Decade of AIDS: A Mental Health Practice Handbook. Walt Odets, Ph.D., and Michael Shernoff, C.S.W., A.C.S.W., eds. New York, NY: Hatherleigh Press; 1995. 313 pages. $29.95 (hardcover); $19.95 (paper).

This handbook is quite timely given the extent of the HIV pandemic and its associated "mental health catastrophe" (p. 1). The main objective of the editors is to provide a theoretical background as well as a practical discussion of the mental health care of HIV-infected patients. The authors review in depth a number of setting-specific issues, including the psychosocial background of the populations most often infected by HIV; certain psychotherapeutic issues likely to be *unfamiliar* to care providers who previously have not worked with HIV-positive/AIDS patients; and special nuances brought on by the HIV setting to *familiar* psychotherapeutic issues.

The book is written primarily for mental health providers, but also for other care givers of HIV/AIDS patients. Sixteen authors, all either clinical or research experts in this field—including psychiatrists, psychologists, social workers, counselors, and psychotherapists—have contributed to 16 chapters. The text of each chapter is preceded by a useful set of summary points and followed by a list of references. The volume is well written and well indexed. However, the organization of the book is hard to understand in that the sequence of chapters does not follow a clear order. Indeed, each chapter serves well as a self-contained unit. All chapters have very focused topics, such as "Counseling long-

term survivors of HIV/AIDS," or "Considerations for presenting HIV/AIDS information to U.S. Latino populations."

The book succeeds in its attempt to provide focused, fairly complete, practical approaches to select mental health problems, which a wide range of clinicians might use with their HIV-infected patients. It is thus a useful basic handbook for providers new to the HIV arena who need to become familiar with these complex topics. However, the volume falls short of its stated goal of providing a theoretical background to the mental health care of the HIV/AIDS patients. It is thus doubtful that physicians or experienced clinicians will benefit from reading this book given its highly specialized nature and lack of theoretical coherence.

Several concerns regarding this work also must be mentioned. The book is intended to be about treatment. However, not enough attention is paid to how treatment fits in the process of evaluating patients, how and when physician consultation might be obtained, or how different treatment approaches are selected over other approaches (e.g., group therapy over counseling). Furthermore, although the contributors use data to document the need for mental health services, almost no evidence is presented to support the use of the specific approaches discussed. Indeed, the attitude implicit in this work is that the need for careful evaluation of the outcomes of treatments is not needed because their success is intuitively obvious and because they cannot possibly have adverse effects on patients—two assumptions with limited basis in fact.

Almost all contributors place great emphasis on comfort and understanding, two essential goals of mental health treatment. Little attention is paid to longevity and recovery from mental distress as treatment goals, and to the transient discomforts that patients must at times face in order to achieve them. For example, patients detoxifying from substances must go through considerable discomfort from withdrawal and craving in order to accomplish full recovery.

Finally, *The Second Decade of AIDS* appropriately places great emphasis on the diversity of the HIV/AIDS populations and on the need to attend to culture-specific issues when caring for these patients. However, this approach at times leaves the impression, I am sure unintended, that highly risky behaviors which have led to serious consequences for those who have practiced them might be excused because we should be accepting of different lifestyles or of these behaviors in members of different cultural groups who have suffered from tremendous discrimination.

CONSTANTINE G. LYKETSOS, M.D., M.H.S.
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■ ■ ■

My Own Country. A Doctor's Story. Abraham Verghese, M.D. New York, NY: Vintage Books. 432 pages. $13 (paper).

With remarkable overtones of Philip Carey in W. Somerset Maugham's *Of Human Bondage* and of Martin Arrowsmith in Sinclair Lewis' *Arrowsmith*, Abraham Verghese gives us an honest and graceful account of his personal haj to an eastern Tennessee culture. There he encountered AIDS in its most flagrant form. Intertwined with many anecdotal episodes, he presents the reader with a better understanding of the latter-day plague than is generally prevalent. Well trained in medicine, Verghese also took special writing courses and so was ably prepared to tell his story.

Born and educated in Ethiopia, Verghese had Indian parents who were physics teachers. They had been born in south India and traced their religious heritage back to the Apostle Thomas, who established Christianity in their country. Rigorous and demanding, their religion instilled in Verghese the empathy and sympathy he later displayed to his patients. He started medical school in Ethiopia, but during a hiatus there, he worked as an orderly in a hospital in the United States before returning to India to complete his education. Again back in this country, he served an internship and residency in medicine in Johnson City, Tennessee. Later, he secured a fellowship in infectious diseases in Boston, after which he returned to a staff position in Johnson City. Here, he began his deep involvement with AIDS.

The newly discovered disease of the 1980s was first considered to exist in major proportion only in the international seacoast cities where homosexual males, prostitutes, and intravenous drug users were congregated. As Verghese unfolds his account in a small town setting, the antipathy and resentment of the healthy population becomes apparent. Mixed with these usual stories are descriptions of those unfortunate individuals who acquired the disease through transfusions or the use of blood products before the now-routine test for the immuno virus was performed.

Dr. John Shaw Billings wrote, "He who aspires to be his brother's keeper must know how his brother lives." Verghese became thoroughly acquainted with his

patients and their families. As a respected physician, he honored his personal commitment to privileged communication from the patient. The danger of spreading inflammatory knowledge is particularly magnified in a rural community due to gossip.

The care of patients with AIDS has grown to be a relatively young specialty for which a base did not exist in the early 1980s. Treatment was more than haphazard until the finer ramifications of the disease were explored and the search for remedies undertaken. The advent of specialists in infectious diseases is producing a more highly trained practitioner who tends to be more caring than therapeutic at the moment.

The treatment of AIDS is not simply a medical problem to be solved, but a human mystery that demands ultra-critical investigation. One of the striking features exhibited by its innocent victims is their manifestation of religious faith which is at a distinct variance with its usual isolation in public discussion of the disease.

In easy manner, the physician unskilled in AIDS may acquire a moderate degree of knowledge about the disease and its unbelievable complications. Pneumonia due to pneumocystis carinii, cytomegalovirus pneumonitis, and *Mycobacterium avium-intracellulare* are among these unusual states.

One startling aspect of this book is the unsavory reference to some city and county hospitals in the United States that became traditional areas for postgraduate training for foreign medical school graduates. Many of these institutions, in critical financial status, had inexorably become wretched asylums. Their patients, indigent and uninsured, had many problems with drug addiction and trauma. An inveterate accompaniment to this scene of horror was the acquisition of foreign physicians, mainly from India and adjacent nations, who provided medical manpower. Such hospitals took these doctors for one year only for unimportant, repetitious work, but never advanced them in the pyramidal system.

These few highlights are but some of the salient features of this book. The reading is easy and the prose is well structured. Physicians and laity will find the information sound and the portraits of the patients intimate, unsentimental, and interesting. The book has the emotional momentum of a good novel because the descriptions of Verghese's patients portray their problems in a compassionate manner. Humans often behave with their fellows in an inhuman way. Verghese, acting in a combination role of doctor, metaphysician, and Christian seeks to allay the fears and resentment of the unaffected toward the less fortunate.

As an intermediary, he sought to bring peace and understanding to his patients and their families. Perhaps the whole purpose of this book is to show that, even if cure is not possible, patients may seek and find a more worthy resolution of their lives to achieve an inner peace which essentially is the goal of healing.

JOSEPH M. MILLER, M.D.
Timonium, Maryland ■

Well Said!

"There is a good deal of nonsense in the preface that Shaw wrote to his play The Doctor's Dilemma, *but one of his conclusions is inescapably right—'Do not try to live for ever. You will not succeed'. Advances in medical technology have not diminished its truth."*

Source: Who owns medical technology? Lancet *1995;345:1125-1126.*

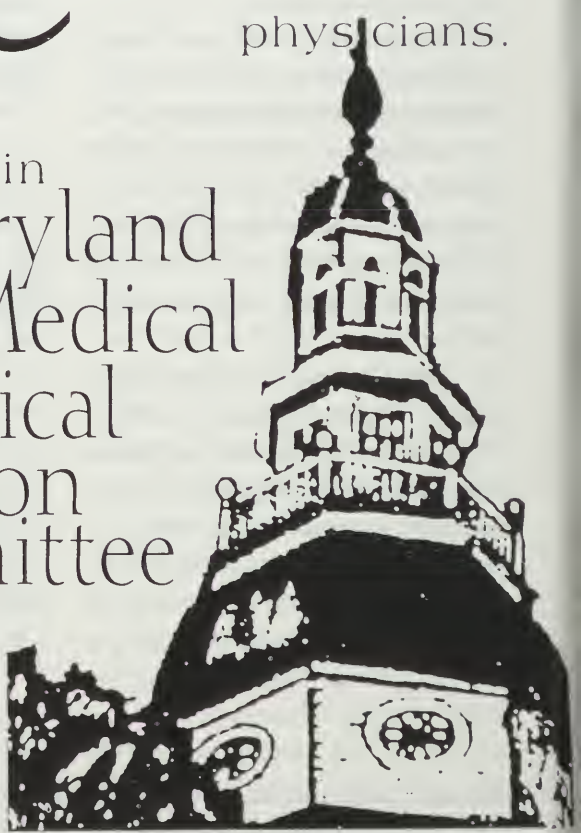
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  Scientific American, August 1995
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  Town & Country, August 1995
- "Diet Pills. Getting Ripped or Getting Ripped Off"
  Muscle & Fitness, September 1995
- "The 8 Diseases Your Doctor Could Miss"
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- "You Won't Feel A Thing"
  New Scientist, July 22, 1995
- "When Depression Comes To Work"
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- "Dr. Nancy Snyderman Answers Questions About Children Eating Dirt and Respiratory Syncytial Virus"
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AIR FORCE

New EMS Palliative Care/DNR Protocol will replace existing hospice protocol

The Maryland EMS Palliative Care/Do-Not-Resuscitate (DNR) Program was approved by the Board of Physician Quality Assurance (BPQA) and went into effect as protocol for ALS and BLS providers July 1, 1995. From July 1, 1995, to September 30, 1995, hospice cards issued under the previous Hospice/EMS Palliative Care Protocol will continue to be honored. During that period, the hospice programs throughout the state will work with their patients to convert from the current hospice cards to the EMS Palliative Care/DNR Order forms and bracelets. Any new patients will receive EMS Palliative Care/DNR Order forms and bracelets starting July 1, 1995, and no new hospice cards will be issued after July 1, 1995. As of October 1, 1995, only the EMS Palliative Care/DNR Order forms and bracelets will be accepted to initiate the EMS Palliative Care/DNR Protocol.

Reasons for DNR program

During the past decade, the issue of a patient's right to self determination—the ability to make health care decisions for oneself—has assumed an increasingly important role in our society and within the emergency medical services community. The legal framework upon which emergency medical service has traditionally been rendered relied heavily on the concept of implied consent. That is, when a patient is unable to provide expressed consent to care (e.g., when unconscious as a result of serious illness or traumatic injury), it is assumed that the patient would want life-saving treatment.

In certain cases, that benevolent assumption is incorrect. There are numerous legal means by which patients can control the medical care they receive if they are unable to participate in the decision-making process. Advance directives such as living wills provide a prospective means by which individuals can specify the kind of medical care they desire under specific circumstances if, in the future, they are unable to do so themselves. For example, individuals with incurable and degenerative diseases may specify the care desired if they lapse into a comatose or noncommunicative state. Advance directives such as durable powers of attorney for health care make it possible for individuals to appoint a trusted person to make health care decisions for them if they are unable to do so. For example, perfectly healthy adults may avail themselves of this provision well in advance of an unforeseen event, such as a traumatic injury, that would render them in a persistent vegetative state.

Although such legal instruments serve patients well in clinical environments, they pose practical problems in life-threatening situations when emergency medical services are called for assistance. Living wills, powers of attorney, and other advance directives are often long and complex and can vary greatly in form and content. There is a very limited amount of time in which EMS personnel must evaluate the situation and take appropriate action. A number of mechanisms have been put in place to make it possible for EMS personnel to respond appropriately to patients' wishes regarding health care in emergency situations.

Maryland was one of the earliest states to address the issue when, in 1988, a Hospice/EMS Palliative Care Protocol was adopted. Although the protocol has served the citizens of Maryland well, it was limited in its applicability to patients enrolled in established hospice programs. In 1991, the Federal Patient-Self Determination Act was passed, which required hospitals and nursing homes that participated in Medicare and Medicaid programs to honor patients' requests regarding end-of-life decisions and to provide patients with information about advance directives. Since that time, more than 20 states have adopted do-not-resuscitate legislation or protocols.

In 1993, the Maryland legislature, recognizing the limitations of the state's hospice protocol and seeking to clarify existing state law with regard to health care decision issues, enacted the Health Care Decision Act. One provision of the act called on the Maryland Institute for Emergency Medical Services System (MIEMSS) to work with the BPQA and other key groups and individuals within the state to develop an EMS palliative care/DNR protocol. The new protocol greatly expands access to palliative care and do-not-resuscitate orders within Maryland. It enables EMS providers to honor patients' wishes to the greatest extent possible with dignity, humanity, and compassion.

Differences between hospice and DNR programs

The Maryland EMS Palliative Care/DNR Program is similar to the Hospice/EMS Palliative Care Program, which it will eventually replace. However, there are important differences. The medical protocol portion is essentially the same for both programs except for minor updates to reflect current medical practice and new airway adjuncts.

The procedural aspects of the two protocols differ significantly. Much of the procedural material of the new EMS Palliative Care/DNR Program has been drawn from, and is set in, the Health Care Decision Act itself. For example, the new protocol calls for an EMS Palliative Care/DNR Order form (**see page 720**) or an optional bracelet (**see page 722**), rather than the hospice card referred to in the current protocol. The EMS Palliative Care/DNR Order is a physician's medical order that appears on a standard form that is the same throughout the state. The order will make rapid identification easier regardless of where EMS personnel practice within the state.

DNR implementation procedure

An information booklet describing the program is available for prehospital care providers. The order forms and bracelets are being distributed to physicians, hospitals, nursing homes, hospices, and other medical facilities upon request. Because the orders will always require a physician's signature to be valid, and counseling and support are vital to the decision-making process, the forms themselves will not be distributed directly to the general public. Individuals interested in the EMS Palliative Care/DNR Program should contact their physician or medical facility for additional information and instructions on how to go about getting an EMS Palliative Care/DNR Order.

A patient or a patient's authorized decision maker contemplating an EMS Palliative Care/DNR Order should review the Health Care Decision Act and consult with the patient's attending physician and legal advisor to understand the applicable provisions of the Act, to determine qualification, and to execute the legal instruments permitted under the Act that may be required prior to the issuance of an EMS Palliative Care/DNR Order. A copy of the Act is included in the information booklet. Condensed instructions on how to complete the EMS Palliative Care/DNR Order can be found on the back of the DNR Order form. Patients or their authorized decision makers may want to consider hospice or home health care for support and counseling related to DNR orders.

DNR Order form & bracelet

The EMS Palliative Care/DNR Order form itself consists of four parts. The actual size of the form is 8½ by 14 inches. The first portion includes information required to identify the patient and the effective date of the order. The second portion is confirmation or acknowledgment by the patient or the patient's authorized decision maker that Palliative Care/DNR status is being requested for the patient. The section must be signed by the patient or the patient's authorized decision maker unless a valid oral or written advance directive was made previously by the patient, when the patient was competent. When a valid, effective advance directive exists, the order need only be signed by the patient's physician. The third portion is the physician certification, which must always be signed by a licensed Maryland physician to be valid. The physician is required to identify which of seven provisions of the Health Care Decision Act a patient qualifies under in order to obtain an EMS Palliative Care/DNR Order. The section also provides emergency telephone numbers for the signing physician and, if the patient is enrolled in a hospice, the hospice support number. These phone numbers are available to EMS personnel should the physician or hospice need to be contacted regarding the patient. The fourth portion of the form is the tear-off insert to the optional Palliative Care/DNR bracelets.

The EMS Palliative Care/DNR Order form and bracelet are designed to be distinctive and readily recognizable. A number of design features have been incorporated to reduce the possibility that the form or bracelet can be intentionally or inadvertently misused. The order consists of an original and a copy. The original is printed on tamper-resistant paper and sequentially numbered. At the bottom of the form is a detachable strip for insertion in a hospital-style bracelet. The bracelet is imprinted with the Star of Life and the moniker *Maryland EMS-DNR*. The copy is readily identifiable as a copy and therefore not valid as an EMS Palliative Care/DNR Order. The copy folds into a preaddressed mailer to be returned to MIEMSS for quality assurance purposes. The bracelets are designed to be moisture-resistant and durable. The bracelet insert contains the same sequential number as the form and also contains a subset of the patient information found on the form. A bracelet alone, without an appropriately completed, sequentially numbered insert, is not a valid DNR order.

If the optional bracelet is to be used, the insert at the bottom of the EMS Palliative Care/DNR Order must be completed and signed by the physician issuing the order. An original order form, or a bracelet with an original insert, has the same effect with respect to initiating the EMS Palliative Care/DNR Protocol. Both need not be present. However, use of the bracelet is optional. The bracelet may be worn about the wrist or hung from a necklace. The wrist location is preferred. EMS personnel are trained to routinely check a patient's wrists and neck

upon initial assessment for signs of circulation and the presence of medical alert devices.

DNR protocol & prehospital care

If an apparently valid EMS Palliative Care/DNR Order form or bracelet is presented to EMS personnel upon their arrival, they will initiate the palliative (comfort care) protocol, which allows for comfort-giving care, rather than resuscitation. If an original EMS Palliative Care/DNR Order form or bracelet with original insert from Maryland or another state is not present and an appropriate oral DNR order is not received by EMS personnel directly from a physician, EMS personnel responding on an ambulance (whether volunteer, commercial, or governmental) or as part of an EMS team, are required by their standing medical protocols to initiate and continue cardiopulmonary resuscitation, including cardiac compression and, depending on their level of certification, licensing, or registration, to perform endotracheal intubation, other advanced airway management techniques, artificial ventilation, defibrillation, and other related life-sustaining procedures. No other written form of DNR Order may be followed by EMS personnel in the prehospital or interfacility setting (other than hospice cards through September 30, 1995).

If a valid EMS Palliative Care/DNR Order is located after resuscitation has begun, EMS personnel may withdraw resuscitative efforts and invoke the palliative (comfort care) protocol, which requires that standard comfort care measures be provided. Ambulance personnel cannot honor specific instructions in advance directives (for example, wants intubation but not CPR) that do not conform to the palliative (comfort care) protocol.

If there is reasonable doubt about the identity of the patient or the validity of an EMS Palliative Care/DNR Order, EMS providers will err on the side of attempting resuscitation. EMS providers acting in good faith are protected from criminal prosecution, civil liability, or administrative action when withholding or withdrawing resuscitation in accordance with the Health Care Decision Act.

An EMS Palliative Care/DNR Order may be revoked at any time by the patient's request for resuscitation made directly to responding emergency medical services personnel **or** by the physical cancellation or destruction of all EMS Palliative Care/DNR Order forms and bracelets with the consent of the patient or the authorized decision maker signing the EMS Palliative Care/DNR Order. Destruction of an EMS Palliative Care/DNR Order or bracelet without consent carries penalties under the Health Care Decision Act.

There is no expiration date for EMS Palliative Care/DNR Orders in Maryland. However, patients, their authorized decision makers, and their attending physicians are encouraged to review at least annually the continuing need, desire, and qualification for an issued EMS Palliative Care/DNR Order.

An original EMS Palliative Care/DNR Order form or bracelet with original insert from Maryland or another state must be present to invoke the palliative (comfort care) protocol. If there is a need to have an EMS Palliative Care/DNR Order in more than one location and it is not practical for the EMS Palliative Care/DNR Order form or bracelet to accompany the patient, more than one original EMS Palliative Care/DNR Order must be issued. Copies will not be honored.

Evaluating DNR program

Although the Hospice/EMS Palliative Care Program was successful in meeting the needs of patients who had access to hospice care, most of the information we have about the effectiveness of the program in meeting the needs of patients and EMS providers is anecdotal. With the EMS Palliative Care/DNR Program, we are asking that a data processing copy of the DNR Order be returned to MIEMSS. The information contained on the form will be protected as a confidential record. The purpose in collecting the information is to evaluate the frequency of use of the EMS Palliative Care/DNR Program and to assess the quality of the program so that we can make future improvements to meet evolving needs. To our knowledge, Maryland is the first state to attempt to close the feedback loop prospectively by providing a means to evaluate the effectiveness of the program.

Additional DNR information

Questions or comments regarding EMS Palliative Care/DNR Orders may be forwarded to MIEMSS by writing to the MIEMSS EMS Palliative Care/DNR Program Office, 636 West Lombard Street, Baltimore, Maryland 21201-1528 or by calling 410-706-4367 (4DNR). Single copies or larger quantities of the EMS Palliative Care/DNR Order forms and bracelets may be acquired free of charge from this office by physicians, hospitals, hospices, nursing homes, and other licensed health care or domiciliary facilities. Recipients may not charge patients for the EMS Palliative Care/DNR Order forms and bracelets provided by MIEMSS. ■

GEORGE SMITH
DNR Program Coordinator

EMS/DNR ORDER#: 123456

DATE ORDER WRITTEN: ☐☐ – ☐☐ – 19☐☐
MONTH DAY YEAR

STOP DO NOT RESUSCITATE

MARYLAND EMERGENCY MEDICAL SERVICES
PALLIATIVE CARE/DO NOT RESUSCITATE (DNR) ORDER

(see instructions on the back)

PATIENT'S FIRST NAME (FN): ☐☐☐☐☐☐☐☐☐☐☐☐

PATIENT'S MIDDLE NAME or MIDDLE INITIAL (MI): ☐☐☐☐☐☐☐☐☐☐☐☐

PATIENT'S LAST NAME (LN): ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

PATIENT'S SOCIAL SECURITY NUMBER (SSN): (see item 13 on back of this form) ☐☐☐ – ☐☐ – ☐☐☐☐

PATIENT'S DATE of BIRTH (DOB): ☐☐ – ☐☐ – 1☐☐☐
MONTH DAY YEAR

PATIENT or AUTHORIZED DECISION MAKER STATEMENT (NOT REQUIRED IF 3 IS INITIALED BELOW)

I, the undersigned individual, am the patient or the patient's authorized decision maker (i.e. agent, guardian, or surrogate) under the Health Care Decision Act, and have requested this EMS Palliative Care/DNR Order from the physician below in accordance with the applicable provisions of the Health Care Decision Act. I hereby direct any and all Emergency Medical Services Personnel who respond and find, or are presented with, an apparently valid EMS Palliative Care/DNR Order: (i) to provide care in accordance with the applicable palliative (comfort care) protocol AND (ii) if pulseless or not breathing, to withhold or withdraw cardiopulmonary resuscitation. I understand that this Order may be revoked at any time by the physical cancellation or destruction of this form and the accompanying bracelet, or, if able, by the patient's oral request for resuscitation. I have been counseled by the undersigned physician, or the physician's delegated representative, and fully understand the implications of this Order. I am authorized by law to make this decision. If the basis of this order is Option 7 and the signatory is a guardian, the guardian, in lieu of the above statement, acknowledges the Order and has no objections to it.

Signature of Patient or Patient's Authorized Decision Maker ☐. ☐☐☐☐☐☐☐☐☐☐☐☐ First Initial and Last Name of Authorized Decision Maker (if applicable)

THE FRONT OF THIS FORM IS PRINTED WITH COLORED SAFETY PAPER – THE WORD "VOID" WILL APPEAR ON ANY COPY

PHYSICIAN CERTIFICATION and ORDER (PHYSICIAN SIGNATURE ALWAYS REQUIRED)

I, the undersigned, am a physician licensed to practice medicine in the State of Maryland. I hereby direct any and all Emergency Medical Services Personnel who respond to this patient and find, or are presented with, an apparently valid EMS Palliative Care/DNR Order: (i) to provide care in accordance with the applicable palliative (comfort care) protocol AND (ii) if they find this patient to be pulseless or not breathing, to withhold or withdraw cardiopulmonary resuscitation, including cardiac compression, endotracheal intubation, other advanced airway management techniques, artificial ventilation, defibrillation, and other related life-sustaining procedures.

For a patient who is CAPABLE of making an informed decision, the basis for this order is as follows (physician to initial in one box next to the appropriate option):

☐ 1. informed decision by the competent patient who signed the patient statement above.

☐ 2. informed decision by the competent patient who signed the patient statement above, which patient has been informed by the attending physician, that the attending physician and one other physician have certified, in a writing which has been reviewed by me and been made part of patient's medical records, that treatment, which under generally accepted medical practices is ordinarily life sustaining in nature, would in this case be medically ineffective in accordance with the Health Care Decision Act, Section 5-611.

For a patient who has been certified to be INCAPABLE of making an informed decision in accordance with the provisions of the Health Care Decision Act, Section 5-606(a), the basis for this order is as follows (physician to initial in one box next to the appropriate option):

☐ 3. currently effective, witnessed, written advanced directive or living will, signed by the patient when capable of making an informed decision, requesting that resuscitation be withheld, which was personally reviewed by me, the physician signing below, and made part of the patient's medical records OR a currently effective, oral advanced directive, made when the patient was capable of making an informed decision, requesting that resuscitation be withheld, which was personally witnessed by the attending physician and one other witness, documentation of which was signed and dated by the attending physician and the witness and made part of the patient's medical records. The patient has been certified to be in a terminal condition, a persistent vegetative state, OR an end-stage condition in accordance with the Health Care Decision Act, Section 5- 606(b).

☐ 4. currently effective, witnessed, written advanced directive (or a durable power of attorney made prior to October 1, 1993), signed by the patient when capable of making an informed decision, which appoints a health care agent and which authorizes the agent to make this decision, which agent has signed the authorized decision maker statement above. Said advanced directive was personally reviewed by me, the physician signing below, and made part of the patient's medical records.

☐ 5. decision by a court-appointed guardian with power over health care matters of the patient, which guardian, with court authorization, has signed the authorized decision maker statement above. A court-appointed guardian, who may be a family member, has precedence in decision making for the patient over a surrogate which has not been appointed a guardian by a court.

☐ 6. decision by a surrogate decision maker for the patient when the patient: (a) has not appointed a health care agent; (b) has no effective advanced directive; (c) has no court-appointed guardian; AND (d) has been certified to be in a terminal condition, a persistent vegetative state, OR an end-state condition in accordance with the Health Care Decision Act, Section 5-606(b). The following individuals or groups, in the specified order of priority, may be surrogate decision makers: (i) the patient's spouse; (ii) an adult child of the patient; (iii) a parent of the patient; (iv) an adult brother or sister of the patient; (v) a friend or other relative of the patient who meets the requirements of Section 5-605(a)(3) of the Health Care Decision Act. Individuals in a particular class may be consulted to make a decision only if all individuals in higher classes are unavailable, as unavailable is defined in the Health Care Decision Act, Section 5-605(a). The surrogate has signed the authorized decision maker statement above.

☐ 7. acknowledgement by the patient's authorized decision maker signing above, which authorized decision maker has been informed by the attending physician that the attending physician and one other physician have certified in writing that treatment, which under generally accepted medical practices is ordinarily life sustaining in nature, will in this case be medically ineffective in accordance with the Health Care Decision Act, Section 5-611.

Any certification of the patient's condition (Section 5-606(b)) or incapability (Section 5-606(a)) or other documentation required by the Health Care Decision Act is contained in the patient's medical records.

Signature of Physician (sign below also, if bracelet is to be used) ☐. ☐☐☐☐☐☐☐☐☐☐☐☐ First Initial and Last Name of Physician

Attending Physician's Emergency Phone Number (☐☐☐)☐☐☐-☐☐☐☐ X ☐☐☐☐ Physician Md. License No. ☐-☐☐☐☐☐

If Hospice Patient, Hospice Phone Number (☐☐☐)☐☐☐-☐☐☐☐ X ☐☐☐☐ Name of Hospice Program ☐☐☐☐☐☐☐☐☐☐☐☐

THE BACK OF THIS FORM CONTAINS A FACSIMILE WATERMARK – HOLD THE BACK AT ANGLE TO VIEW

ORIGINAL COPY
(Keep with Patient – See Instructions on Back)

© MIEMSS 1995

(separate at perforation) (separate at perforation)

Type or print legibly, have physician sign, tear off strip, fold, trim and insert in bracelet



fold

ORDER #: 123456

M.D. Sign: _____ Order Date: ___/___/___

M.D. Name: _____ M.D.Ph.# (___) _____

Pt. Name: _____ Pt. DOB: ___/___/___

INSTRUCTIONS

1. This EMS Palliative Care/DNR Order is authorized and enabled by the Health Care Decision Act, codified as Subtitle 6 of the Health-General Article, by Sections 14-205, 14-303, and 14-305, Health Occupations Article and by Section 13-1D-08(a)(1) of the Education Article, all of the Annotated Code of Maryland. The EMS Palliative Care/DNR Program has been developed by the Maryland Institute for Emergency Medical Services Systems (MIEMSS), an independent agency of the State of Maryland, in conjunction with the Board of Physician Quality Assurance, pursuant to Section 5-608 of the Health-General Article of the Annotated Code of Maryland.

2. Patients or their authorized decision makers contemplating an EMS Palliative Care/DNR Order, should review the Health Care Decision Act and consult with the patient's attending physician and legal advisor, in order to understand the applicable provisions of the Act, to determine qualification, and to execute those legal instruments, permitted under the Act, that may be required prior to the issuance of an EMS Palliative Care/DNR Order. Patients or their authorized decision makers may want to consider hospice or home health care for support and counseling related to do not resuscitate orders.

3. This EMS Palliative Care/DNR Order is only valid if signed by:

   a) For options 1, 2, 4, 5, 6, and 7, the patient's physician AND, as required on the EMS Palliative Care/DNR Order form, the patient or the patient's authorized decision maker; or

   b) For option 3, the patient's physician only.

4. With the adoption of the Health Care Decision Act, the EMS Palliative Care/DNR Program replaces and expands upon the previous Hospice/EMS Palliative Care Program. Beginning 7/1/95, when the new EMS Palliative Care/DNR Program will take effect, hospice cards will no longer be issued by the Hospice Network of Maryland and its member hospice programs. Hospice cards issued prior to 7/1/95 will continue to be recognized by ambulance personnel through 9/30/95. During this 3 month period, hospice programs will convert hospice cards to EMS Palliative Care/DNR Orders. After 9/30/95 hospice cards will no longer be honored. Hospice programs will continue to provide their traditional services using EMS Palliative Care/DNR Orders in lieu of hospice cards.

5. To issue an EMS Palliative Care/DNR Order:

   a) Complete the EMS Palliative Care/DNR form and bracelet insert, and

      i) Have the patient (if capable of making an informed decision and physically able) or an authorized decision maker (i.e. agent, guardian, or surrogate) sign the "Patient or Authorized Decision Maker Statement". The "Patient or Authorized Decision Maker Statement" does not need to be signed if the patient has previously signed an advanced directive requesting that resuscitation be withheld (see Option 3 under the section entitled "Physician Certification and Order").

      ii) Have the physician sign the "Physician Certification and Order" and initial one of the seven options. If the bracelet is to be used, have the physician sign the bracelet insert at the bottom of the EMS Palliative Care/DNR Order.

   b) The "MIEMSS Copy" of <u>each</u> EMS Palliative Care/DNR Order should be forwarded to the MIEMSS EMS Palliative Care/DNR Program Office. The "MIEMSS Copy" folds into a convenient, pre-addressed mailer which requires no postage. If desired, for greater confidentiality, the copy may be forwarded in an envelope provided and addressed by the sender.

   c) If the bracelet will be used, be sure the insert has been completed and signed, tear the bracelet insert off of the original form, fold it, trim it along the dashed line, and insert it in the EMS Palliative Care/DNR bracelet that has been provided. The bracelet may be worn about the wrist or hung from a necklace. The wrist location is preferred. EMS personnel are trained to routinely check a patient's wrists and neck upon initial assessment for signs of circulation and the presence of medical alert devices.

   d) The EMS Palliative Care/DNR Order form should be kept in the following places and be retrieved for responding EMS personnel, preferably before their arrival:

      i) At medical facilities, an EMS Palliative Care/DNR Order may be kept in the patient's chart so that the EMS Palliative Care/DNR Order will be readily available to EMS personnel;

      ii) In residences and domiciliary facilities, an EMS Palliative Care/DNR Order may be kept by the bedside, behind the patient's bedroom door, or on the refrigerator door (i.e. uniform visible locations for easy retrieval by EMS personnel when no caregiver is present). The preferred location is behind the patient's bedroom door;

      iii) In schools and educational institutions, an EMS Palliative Care/DNR Order may be kept on file in the nurse's office or health room so that the EMS Palliative Care/DNR Order will be readily available to EMS personnel.

      iv) Ambulatory DNR patients venturing away from their residence or health care facility alone, are encouraged to wear the bracelet on their wrist or hanging from a necklace, as EMS personnel are not permitted to go through a patient's personal effects to locate an EMS Palliative Care/DNR Order form.

6. If an apparently valid original EMS Palliative Care/DNR Order form or bracelet with original insert from Maryland or another state <u>is presented</u> to EMS personnel <u>upon</u> their <u>arrival</u>, they will initiate the palliative (comfort care) protocol, that allows for comfort giving care, rather than resuscitation.

7. If an original EMS Palliative Care/DNR Order form or bracelet with original insert from Maryland or another state <u>is not present</u> and an appropriate oral DNR order is not received by EMS personnel directly from a physician, emergency medical services personnel responding on an ambulance (whether volunteer, commercial, or governmental) or as part of an emergency medical services team, are required by their standing medical protocols to initiate and continue cardiopulmonary resuscitation including cardiac compression, and depending on their level of certification, licensing, or registration, to perform endotracheal intubation, other advanced airway management techniques, artificial ventilation, defibrillation, and other related life-sustaining procedures. No other <u>written</u> form of DNR Order may be followed by emergency medical services personnel in the pre-hospital or interfacility setting (other than hospice cards through 9/30/95).

8. If a valid EMS Palliative Care/DNR Order is located after resuscitation has begun, EMS personnel may withdraw resuscitative efforts and invoke the palliative (comfort care) protocol which requires that standard comfort care measures be provided. Ambulance personnel cannot honor specific instructions in advance directives that do not conform to the palliative (comfort care) protocol (i.e. wants intubation but no CPR).

9. If there is reasonable doubt about the identity of the patient or the validity of an EMS Palliative Care/DNR Order, EMS providers will err on the side of attempting resuscitation. EMS providers acting in good faith are protected from criminal prosecution, civil liability, or administrative action when withholding or withdrawing resuscitation in accordance with the Health Care Decision Act.

10. An EMS Palliative Care/DNR Order may be revoked at any time by the patient's request for resuscitation made directly to responding emergency medical services personnel **<u>OR</u>** by the physical cancellation or destruction of all EMS Palliative Care/DNR Order forms and bracelets with the consent of the patient or the authorized decision maker signing the EMS Palliative Care/DNR Order. Destruction of an EMS Palliative Care/DNR Order or bracelet without consent carries penalties under the Health Care Decision Act.

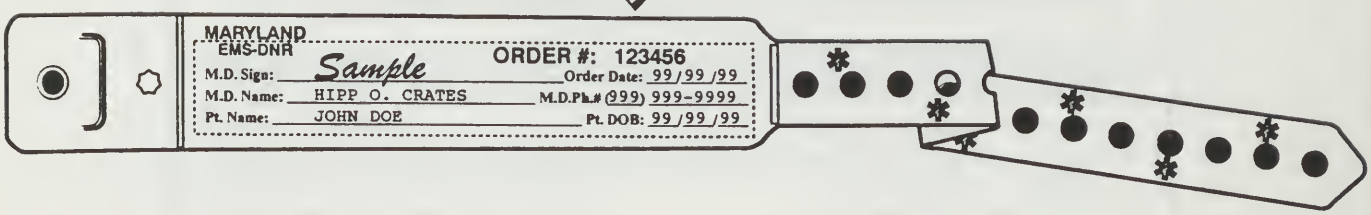
11. There is no expiration date for EMS Palliative Care/DNR Orders in Maryland. However, patients, their authorized decision makers, and attending physicians are encouraged to review the continuing need, desire, and qualification for an issued EMS Palliative Care/DNR Order at least annually.

12. An **<u>ORIGINAL</u>** EMS Palliative Care/DNR Order form **<u>OR</u>** bracelet with **<u>ORIGINAL</u>** insert must be present to invoke the palliative (comfort care) protocol. If there is a need to have an EMS/DNR Order in more than one location and it is not practical for the EMS Palliative Care/DNR Order form or bracelet to accompany the patient, more than one original EMS Palliative Care/DNR Order must be issued. <u>Copies shall not be honored</u>.

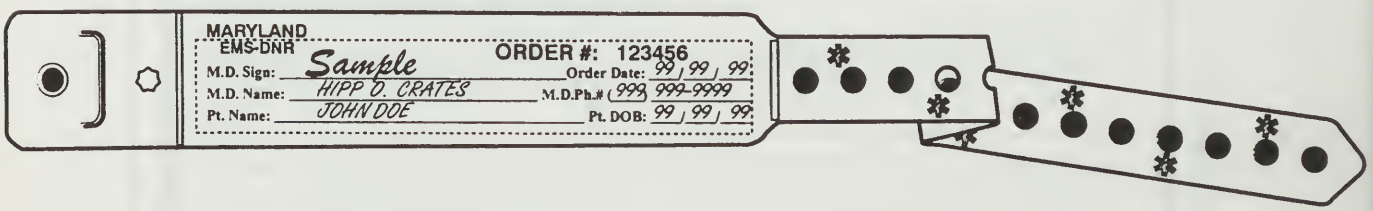
13. The copy of the EMS Palliative Care/DNR Order sent to MIEMSS shall be used for quality assurance purposes, to determine the utility and effectiveness of the EMS Palliative Care/DNR Program. It is a confidential record under Section 14-503 of the Health Occupations Article of the Annotated Code of Maryland. Its release by MIEMSS, except in a manner which does not disclose the identity of any person, is prohibited. Persons providing confidential information to MIEMSS are protected by Section 5-302 of the Courts and Judicial Proceedings Article of the Annotated Code of Maryland. As required by Federal Privacy Act of 1974 (5 U.S.C. 552(a)), users of this form are advised that (a) disclosure of the social security number requested on the EMS Palliative Care/DNR Order form is voluntary (b) disclosure is requested under the authority of Section 5-601(h) of the Health General Article of the Annotated Code of Maryland, and (c) the number shall be used for the sole purposes of (i) uniquely identifying patients with the same or similar names and (ii) for research and statistical analysis, through linkage with vital records, of access by patients with EMS Palliative Care/DNR Orders to the EMS system and entrance and exit of these patients from the EMS Palliative Care/DNR Program.

14. Questions or comments regarding EMS Palliative Care/DNR Orders may be forwarded to MIEMSS by writing to the MIEMSS EMS Palliative Care/DNR Program Office, 636 West Lombard Street, Baltimore, Maryland 21201-1528 or by calling (410) 706-4367. Single copies or larger quantities of the EMS Palliative Care/DNR Order forms and bracelets may be acquired free of charge from this Office by physicians, hospitals, nursing homes, and other licensed health care or domiciliary facilities. Recipients may not charge patients for the EMS Palliative Care/DNR Order forms and bracelets provided by MIEMSS.

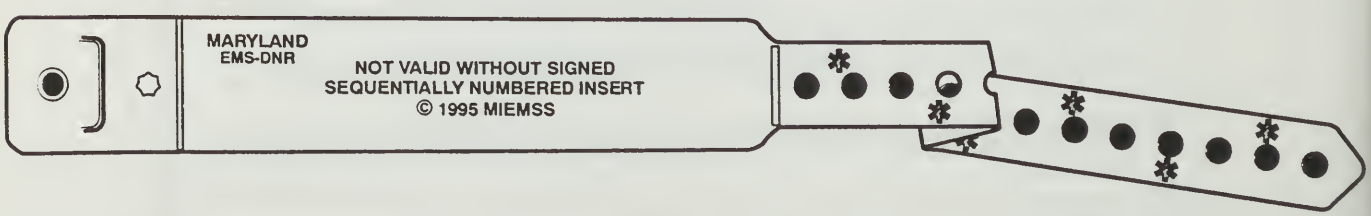
TYPED SAMPLE



HANDWRITTEN SAMPLE



BRACELET WITHOUT INSERT



Alliance

Maryland State Leadership Confluence

The first leadership confluence workshop sponsored by the Alliance to the Medical and Chirurgical Faculty of Maryland will be held September 13, 1995, at the Med Chi building in Baltimore. The one-day meeting, patterned after the national Alliance leadership confluence, will include speakers from both the national Alliance and the Med Chi Alliance.

AGENDA

8:00 a.m. ..... *Continental breakfast*

8:30 a.m. ..... *Opening remarks*
J. Richard Lilly, M.D., Med Chi president (introduced by Angelo J. Troisi, F.A.C.H.E., Med Chi chief executive officer)

9:00 a.m. ..... *The Art of Leadership*
Mildred Taylor, SMAA past president

9:45 a.m. ..... *Parliamentary Procedure*
Helen Boyer, AMCFM past president and parliamentarian

10:30 a.m. ..... *Coffee break*

11:00 a.m. ..... *Membership Development*
Diane Chow, AMAA field director

12:30 p.m. ..... *Questions and Answers*
Panel of speakers

1:00 p.m. ..... *Luncheon and social hour*

MARYLAND

The Alliance always welcomes new members.

Alliance members support the physicians and are recognized for their contributions to health, education, and the promotion of quality health care in Maryland.

For information on becoming a member, call JoAnn Troisi at Med Chi's Alliance office.
539-0872 (Baltimore area)
1-800-492-1056 (toll free in MD)



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University of Maryland School of Medicine

For each course, additional information may be obtained by contacting the Program of Continuing Education, University of Maryland School of Medicine, Room 14-011, BRB, 655 W. Baltimore St., Baltimore, MD 21201 (410-706-3956) or by calling the phone number listed after a specific program. FAX 410-706-3103.

Recent advances in kidney & pancreas transplantation, at the Warehouse, Oriole Park at Camden Yards, Baltimore, MD. 4 Cat 1 AMA credits. Fee: $35. Info: Sharon Stenhouse, 410-706-3958. — **Sept. 16**

Topics in pulmonary medicine, at the Stouffer Harborplace Hotel, Baltimore, MD. 10.5 Cat 1 AMA credits. Fee: $175. Info: Larry R. Sauder, 410-706-4497. — **Sept. 16–17**

1995 Advanced preoperative evaluation and planning for complex deformities, at the Pikesville Hilton Inn, Baltimore, MD. 25 Cat 1 AMA credits, 6 optional. Fee: $450. Info: Steven Kaniecki, 410-448-3394. — **Sept. 16–19**

Women's health issues for the primary care provider, at the Sheraton Inn, Baltimore, MD. 7.5 Cat 1 AMA/AAFP credits. Info: Althea Pusateri, 410-706-3957. — **Sept. 29**

Recent advances in the treatment of mood disorders: controversy and consensus, at the Baltimore VAMC, Baltimore, MD, sponsored by the Department of Veteran Affairs and University of Maryland School of Medicine. 4 Cat 1 AMA credits. Fee: $35. Info: Susan Reed, 410-605-7000, ext. 6063, or Althea Pusateri, 410-706-3957. — **Sept. 30**

7th Annual Maryland conference—AIDS: a challenge to primary care: science, practice, art, at the Baltimore Convention Center, Baltimore, MD. 9 Cat 1 AMA credits. Fee: $240. Info: Sylvia Scherr, 410-328-5759. — **Oct. 5–7**

Treatment in epilepsy/Epilepsy Association of Maryland, at the Holiday Inn, Frederick, MD. 5 Cat 1 AMA credits. Fee: $50. Info: Cathy Bowers, 410-828-7700. — **Nov. 3**

Endocrinology and metabolism update for the practicing physician—1995, at the Pier 5 Clarion Inn, Baltimore, MD. 10 Cat 1 AMA credits. Fee: $185. Info: John Wilber, M.D., Connie Ball, 410-328-2515. — **Nov. 3–4**

Cyrus L. Blanchard and Bernard S. Kleiman lectures on head and neck trauma, at the University of Maryland Medical School teaching facility, Baltimore, MD. 8 Cat 1 AMA credits. Fee: $100. Info: Charles M. Suter, Ph.D. — **Nov. 10–11**

Pollin Fellowship conference: crisis counseling for patients and families with chronic medical illnesses, at the Radisson Lord Baltimore, Baltimore, MD. 6 Cat 1 AMA credits. Fee: $45. Info: Vertell Porter-Brown, 410-328-6735, or Sharon M. Stenhouse, 410-706-3958. — **Nov. 17**

Self-Directed CME Activities

Optimal dosing in chemotherapy: adoptive control with carboplatin, video tape, monograph and test. Expires March 1996. 3 Cat 1 AMA credits. Info: 212-924-3044.

U.S. medical costs and values: primary prevention versus end stage treatment, monograph and test. Expires Aug. 1996. 2 Cat 2 AMA credits. Info: 908-281-3772.

Lipid management for coronary heart disease: a proven hypothesis, audio tape and test. Expires Aug. 1996. 1 Cat 2 AMA credit. Info: 609-497-9743.

Drug-drug interaction: Focus on antidepressants, monograph w/response test. Expires Aug. 30, 1996. 2 Cat 1 AMA credits. Info: 203-629-2555.

University of Maryland School of Medicine (continued)

Continuously throughout the year

Academic rounds and conference, each academic department within the school of medicine has a series of lectures and/or seminars available to physicians. Cat 1 AMA credits available. Info: 410-706-3956.

Miscellaneous meetings

1995 Risk management program: suit survival/lessons in risk management, sponsored by Medical Mutual Liability Insurance Society of MD. Med Mutual members who attend will receive a 5% discount on 1996 renewal premium. 2 Cat 1 AMA credits. Fee: $40. Info: Toni Davis or Natalie Poole, 410-785-0050, or 1-800-492-0193.

Anne Arundel Med. Ctr., Annapolis	**Sept. 7**
Med Chi Semiannual Meeting, Ocean City	**Sept. 9**
Medical Mutual, Hunt Valley	**Sept. 11**
Harford Memorial, Havre de Grace	**Sept. 12**
Cambridge Yacht Club, Cambridge	**Sept. 13**
Doctors Community Hospital, Lanham	**Sept. 14**
Medical Mutual, Hunt Valley	**Sept. 18**
Holy Cross Hospital, Silver Spring	**Sept. 19**
Frederick Memorial Hospital, Frederick	**Sept. 21**

Med Chi's 1995 Semiannual meeting: Working together—Primary care for specialists; Specialty care for primary care physicians, at the Princess Royale Oceanfront Hotel and Conference Center, Ocean City, MD. Up to 16 Cat 1 AMA credits available. No fee for members. Info: 410-539-0872, or in MD, 800-492-1056. **Sept. 8–10**

Textbook-based continuing medical education conference based on *Treatments of Psychiatric Disorders, 2nd edition,* sponsored by the American Psychiatric Association in collaboration with the American Psychiatric Press, Inc., in Washington, DC. 15 Cat 1 AMA credits. Info: 202-682-6145. **Sept. 8–10**

Diabetic retinopathy: a comprehensive review & update, sponsored by the Retina Institute of Maryland at the Stouffer Harborplace Hotel, Baltimore, MD. 7.5 Cat 1 AMA credits. Fee: $250/physicians; $100/other. Info: 410-337-4500. **Sept. 15**

6th Biannual gastroenterology board review course, sponsored by the George Washington University Medical Center, at the Grand Hyatt, Washington, DC. Fee and credits TBA. **Oct. 7–11**

Medical oncology board review course, sponsored by the George Washington University Medical Center, at the Ritz-Carlton Pentagon City, Arlington, VA. Fee and credits TBA. **Oct. 8–12**

New techniques and concepts in cardiology, sponsored by the American College of Cardiology in Washington, DC. 16.5 Cat 1 AMA credits available. Info: 800-257-4739. **Oct. 19–21**

Mental health of women throughout the life span conference, at Sheppard Pratt Conference Center, Baltimore, MD. 6 Cat 1 AMA/PRA credits. Fee: TBA. Info: 410-938-4598. **Oct. 21**

Miscellaneous meetings (continued)

Palliative care and the hospice concept, at GBMC in Baltimore, MD. 4 Cat 1 AMA credits. Fee: $50/physicians; $25/residents. Info: Ann Harris, 410-828-3670. — **Oct. 28**

Care of the asthmatic patient: a multidisciplinary approach, at GBMC in Baltimore, MD. 7 Cat 1 AMA credits. Fee: $40/physicians and residents. Info: Ann Harris, 410-282-3670. — **Nov. 1**

Pediatric ophthalmology: an update for pediatricians and family practitioners, at the GBMC Conference Center, Baltimore, MD. 4 Cat 1 AMA credits. Info: Ann Harris, 410-828-3670. — **Nov. 4**

St. Joseph Medical Center Annual Symposium: The interface of medicine and psychiatry, at the Noppenberger Auditorium of St. Joseph Medical Center, Towson, MD. 6 Cat 1 AMA/PRA/AAFP credits. Fee: $45/physicians; $45/psychologists; $25/house staff, nurses, allied health professionals. Registration deadline: Oct. 27. Info: Pat Fuchsluger at 410-337-1501. — **Nov. 4**

Oncology issues for primary care physicians, sponsored by the Maryland Academy of Family Physicians at the Columbia Inn, Columbia, MD. 6.75 Cat 1 AMA/AAFP credits. Fee: $55/members; $75/nonmembers; $35/allied health professionals. No fee for inactive/life members/residents/medical students. Info: Maria E. Delgado, M.D., 410-747-1980. — **Nov. 11**

Twelfth annual clinical update in pulmonary medicine CME course and luncheon, at the Trump Regency Hotel in Atlantic City, NJ, sponsored by the department of pulmonary medicine, Deborah Heart and Lung Center. CME TBA. Info: 201-385-8080. — **Nov. 19**

Modern approaches to office emergencies, sponsored by the Maryland Academy of Family Physicians at the Annapolis Waterfront Hotel, Annapolis, MD. 10 Cat 1 AMA/AAFP credits. Fee: $115/members; $150/nonmembers; $65/allied health professionals. No fee for inactive/life members/residents/medical students. Info: Maria E. Delgado, M.D., 410-747-1980. — **Feb. 3–4**

Continuously throughout the year

Fluorescein angiography conference, sponsored by the Retina Center, Saint Joseph Hospital, Baltimore, MD, first and third Mondays of each month; 8:00–9:00 am. Fee: none. Info: R. Classon, 410-337-4500.

Sinai Hospital of Baltimore medical grand rounds, in the Zamoiski Auditorium on Thursdays, 9:00—10:00 am. Info: 410-578-5528.

Pulmonary hypertension	**Sept. 7**
Sickle cell disease: recent advances in therapy	**Sept. 14**
First step choice of antihypertensive therapy to prevent coronary heart disease and renal insufficiency	**Sept. 21**
Resuscitation of patients with circulatory shock	**Sept. 28**
Adult immunization	**Oct. 5**
Chronic fatigue syndrome: fact or fiction	**Oct. 12**
Glaucoma: facts and fancies	**Oct. 19**
Leukotrienes in asthma	**Oct. 26**
Treating seizures in the decade of the brain	**Nov. 2**

Miscellaneous meetings (continued)

Diabetic retinopathy	**Nov. 9**
AIDS: the state of the syndrome	**Nov. 16**
Acute myocardial infarction	**Nov. 30**
The renin-angiotensin system	**Dec. 7**
Community-acquired pneumonias	**Dec. 14**
Medical interviewing and the doctor-patient relationship in the managed care era	**Dec. 21**

The Johns Hopkins Medical Institutions

All courses at the Thomas B. Turner Building unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Medical Education, 720 Rutland Ave., Baltimore, MD 21205 (410-955-2959).

Practical issues in the diagnosis and treatment of glaucoma, up to 7.5 Cat 1 AMA credits available. **Sept. 2**

Third annual airway management, Cat 1 AMA credits available. Fees: $700 physicians; $500/residents and allied health professionals, $350/one-day fee. **Sept. 8–10**

Johns Hopkins hepato-biliary update at the Sheraton Fontainebleau Hotel, Ocean City, MD. Up to 11 Cat 1 AMA credits and 10 AAFP credits available. Fee: $325. **Sept. 8–10**

Third annual progress in hematologic malignancies and bone marrow transplantation and pediatric hematology and oncology for the pediatrician, at the Stouffer Renaissance Harborplace Hotel, Baltimore, MD. 11.5 Cat 1 AMA credits available. Fee: $95/physicians and nurses. **Sept. 14**

Pediatrics for the practitioner: update '95, up to 14 Cat 1 AMA credits available. **Sept. 14–15**

24th Annual diagnostic ultrasound in obstetrics and gynecology and abdomen, at the Stouffer Renaissance Harborplace Hotel, Baltimore, MD. Up to 16.5 Cat 1 AMA credits available. **Sept. 15–17**

11th Birth conference: innovations in perinatal care, assessing benefits and risks, at the Hyatt Regency Baltimore Hotel, Baltimore, MD. Up to 13 Cat 1 AMA credits available. Fee: $300/physicians; $215/allied health professionals. **Oct. 7–8**

21st Annual topics in gastroenterology and liver disease, Up to 24 Cat 1 AMA credits available. Fee: $525/physicians; $275/residents and fellows; postmarked before 9/4/95, $495/physicians; $250/residents and fellows. **Oct. 11–13**

The second hands-on flexible sigmoidoscopy course, 7 Cat 1 AMA credits. Fee: $550/physicians; $400/residents, fellows. **Oct. 14**

37th annual Emil Novak memorial course: gynecology, gynecological pathology, endocrinology and high-risk obstetrics and second annual Richard W. Telinde lecture, at the Stouffer Renaissance Harborplace Hotel, Baltimore, MD. Up to 55.5 Cat 1 AMA credits available. **Oct. 14–19**

The second prevention of coronary heart disease, at the Sheraton Baltimore North Hotel, Baltimore, MD. Up to 8 Cat 1 AMA credits available. Fee: $175/physicians; $130/residents, fellows, allied health professionals. **Oct. 18**

The Johns Hopkins Medical Institutions (continued)

Comprehensive management of salivary gland neoplasms, up to 10 Cat 1 AMA credits available.	**Oct. 26–27**
Progress in pediatrics, 11 Cat 1 AMA credits. Fee: $150/physicians; $80/residents, fellows, nurse practitioners.	**Nov. 3–4**
Second international symposium on medical robotics and computer-assisted surgery, at the Marriott Inner Harbor Hotel in Baltimore, MD. 24 Cat 1 AMA credits.	**Nov. 4–7**
Advanced pediatric life support, 20 Cat 1 AMA credits.	**Nov. 13–15, June 10–12**
Topics in ambulatory medicine VII, at the Stouffer Renaissance Harborplace Hotel, Baltimore, MD. 18 Cat 1 AMA credits. Fee: $500/physicians; $300/residents, fellows and allied health professionals.	**Nov. 15–17**
Diabetic retinopathy and venous occlusive disease, 8 Cat 1 AMA credits.	**Nov. 17**
Innovations in uveitis and ocular infections, 8 Cat 1 AMA credits.	**Nov. 18**
Impact of changing regulations on clinical trials, 15 Cat 1 AMA credits.	**Nov. 29–30**
Sixth annual neurology for the primary practitioner, at the Harbor Court Hotel in Baltimore, MD. 6 Cat 1 AMA credits.	**Dec. 2**
Eighth annual Wilmer Institute current concepts in ophthalmology, 20 Cat 1 AMA credits.	**Dec. 7–9**

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During July 1995, the physicians listed below received the American Medical Association (AMA) Physician's Recognition Award. Established in 1968, the award's purpose is to encourage physician participation in continuing medical education and to recognize those physicians who have voluntarily completed programs of continuing medical education.

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September, 1995
Selected Communicable Diseases in Maryland in 1994
(Continued from July & August, 1995)

MENINGITIS, VIRAL (ASEPTIC) (244)
4.9/100,000 (U.S. 3.1/100,000)

The 1994 total of 244 cases is reduced from the 245 shown in Table 1 (see the July 1995 issue). The highest rate per 100,000 population (10.4) was observed in Caroline County. Almost half (46%) of the cases occurred in June, July, and August.

The ratio of male to female cases was 0.66:1. The ratio of whites to non-whites was 2.1:1; for 23 (9.4%) cases, race was unknown. Age-related incidence was highest (14.6/100,000 population) in the birth to 4 year age group, and most (75%) of the 55 cases in that group occurred in children <1 year old.

The etiology was reported for only 10 cases: 4 enterovirus, 3 coxsackie virus, 1 adenovirus, and 1 herpes virus.

MENINGOCOCCAL DISEASE (28)
0.6/100,000 (U.S. 1.0/100,000)

The 28 reported cases is an adjustment from the 32 cases that appeared in Table 1 (see the July 1995 issue). This is the fewest number of cases to be reported in the last 5 years. Five cases each were reported in Baltimore City, Baltimore County, and Prince George's County.

The ratio of male to female cases was 1.8:1 and the ratio of whites to non-whites was 2.4:1. The highest incidence, 2.4 per 100,000 population, occurred in the birth to 4 year age group, with 5 of the 9 cases occurring in those less than 1 year of age. A second peak in age-related incidence occurred in the 15-19 age group (1.3/100,000 population). Thirteen of the cases presented with meningococcemia, 13 with meningitis, 1 with arthritis, and 1 with pneumonia. There were 3 deaths among the 26 cases where outcome is known, for a case fatality rate of 12%.

MUMPS (65)
1.3/100,000 (U.S. 0.5/100,000)

The trend in the number of mumps cases over the past 10 years is shown in Figure 10. The number of cases reported in 1994 by jurisdiction is shown in Table 1 (see the July 1995 issue).

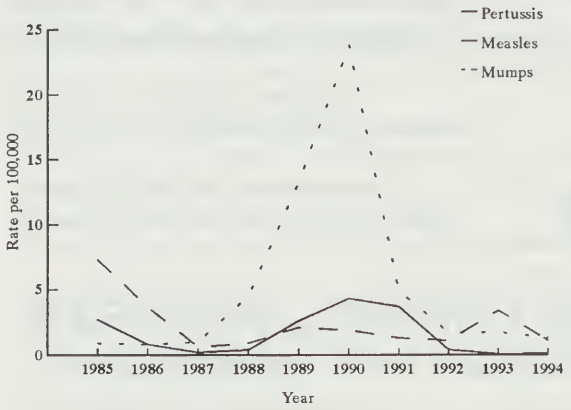


Fig 10. Measles, mumps and pertussis. Incidence, Maryland, 1985-1994.

The ratio of male to female cases was 1.1:1 and that of whites to non-whites was 2.3:1 (race was unknown for 12 cases, 18%). Forty-seven cases (72%) occurred in those less than 15 years of age; the highest rate per 100,000 population, 6.2, was in the 5-9 year age group.

PERTUSSIS (53)
1.1/100,000 (U.S. 1.4/100,000)

The number of pertussis cases reported in 1994 decreased 68% from the number reported in 1993 (167). The trend over the past 10 years is seen in Figure 10. The number of cases by jurisdiction in 1994 is shown in Table 1 (see the July 1995 issue). There were no outbreaks.

The ratio of male to female cases was 1:1.3. The ratio of white to non-white cases was 2.2:1. Ages ranged from 14 days to 70 years. The median age was 3 years. Twenty-four cases (45%) were under age 1, including 3 newborns (6%), and 11 (21%) who were 1-5 months old.

The following symptoms were reported: paroxysmal cough in 48 (92%), post-tussive vomiting in 28 (53%), whoop in 30 (58%), cyanosis in 13 (25%), and apnea in 13 (25%). No deaths were reported.

Eighteen cases (34%) were culture confirmed, 9 (50%) of which were also DFA positive.

ANIMAL RABIES (520)
(U.S. 7347)

All of Maryland became involved in an epizootic of raccoon rabies when the lower Eastern Shore, Somerset and Worcester Counties, became rabies endemic in 1993. The trend of animal rabies in Maryland over the past 14 years, since the beginning of the current terrestrial epizootic, is shown in Figure 11.

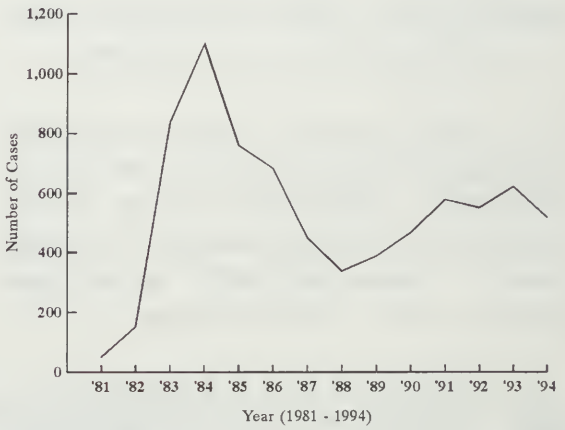


Fig 11. Animal rabies. Cases reported, Maryland, 1981-1994.

In 1994, 520 of the 5,211 animals submitted for laboratory examination were rabies positive. There where fewer cases in 1994 (520) than in 1993 (624), a 17% decrease.

Raccoons continue to be the most frequent laboratory confirmed rabid animal (412, 79%) and are the only maintenance host in Maryland. Other spillover species reported with rabies are: skunk (55, 11%), fox (30, 6%), cat (9, 2%), groundhog, dog, horse, steer, and ferret (each <1%). Bat rabies that is unrelated to the raccoon epizootic continues to occur (<1% of positive animals).

Since rabies became endemic in Maryland in September, 1981, 161 cats have been confirmed rabid. Therefore, cats are a major source of concern for rabies transmission because of the frequent human exposures. However, there have been no human cases of rabies in Maryland since one resulting from a bat bite in 1976.

ROCKY MTN. SPOTTED FEVER (20) 0.4/100,000 (U.S. 0.2/100,000)

The number of cases in 1994 (20) is reduced from the 22 shown in Table 1 (see the July 1995 issue). Cases were reported from 10 counties, ranging from Washington County in Western Maryland to Talbot County on the Eastern Shore. The highest incidence rates per 100,000 population were reported from Dorchester County (6.6) and Saint Mary's County (6.2). Onsets occurred from April to October; June was the peak month with 7 cases (35%). The age of cases ranged from 5 to 73 years (median 34 years). The ratio of male to female cases was 0.58:1. Among the 16 cases where race was identified, all were white. Five were hospitalized and 1 death was reported.

Eleven cases gave more detailed information on symptoms and tick exposure. Nine had a rash, including 3 with rash on the palms and/or soles. Four (36%) reported a tick bite or attachment, 4 reported exposure to a tick infested area (without a definite bite or attachment), and 3 (27%) had neither of the above exposures.

SALMONELLOSIS (1167) 23.3/100,000 (U.S. 16.6/100,000)

The 1,167 reported cases for 1994 is an adjustment from the 1,177 seen in Table 1 (see the July 1995 issue). The trend in the number of reported cases of salmonellosis over the past 10 years is seen in Figure 12. The peak in illness onsets occurred in the warmer months with 51% of the cases reporting an onset in June through September. Fifteen outbreaks of salmonellosis were reported from 10 counties: 12 resulted from foodborne transmission, 2 from animal contact, and 1 from person-to-person spread in a children's day care center. These outbreaks accounted for 39 laboratory confirmed cases and an additional 109 epidemiologically linked cases.

The ratio of male to female cases was 0.95:1. Among the 906 cases for whom the race was known, the ratio of whites to non-whites was 1.7:1. Children from birth through 4 years of age had the highest rate per 100,000 population (85.4). Among adults, the highest rates were in the age groups 20-29 years (20.5) and 30-39 years (20.2).

Of the 904 isolates for which serotype was available, 353 (39%) were *S.* Enteritidis (compared to 34% in 1993, 40% in 1992, and 37% in 1991). The four other most frequently reported serotypes were: *S.* Typhimurium (195, 22%), *S.* Heidelberg (46, 5%), *S.* Newport (46, 5%), and *S.* Hadar (37, 4%).

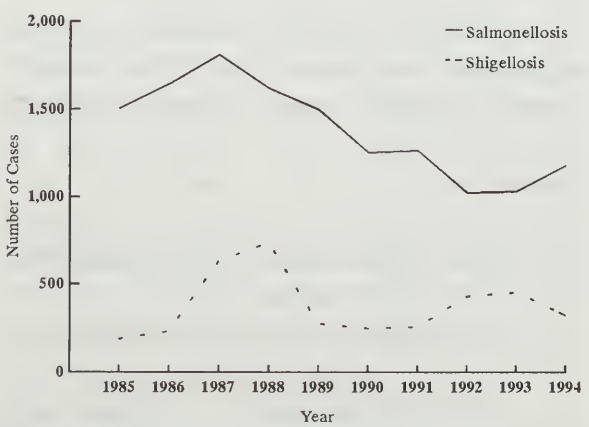


Fig 12. Salmonellosis and shigellosis. Cases reported, Maryland, 1985-1994.

SHIGELLOSIS (323)
6.5/100,000 (U.S. 11.4/100,000)

The number of cases by jurisdiction is shown in Table 1 (see the July 1995 issue). Seventy-seven percent of the cases occurred in Baltimore City, Montgomery County, and Prince George's County, which account for just 45% of the State's population. Those jurisdictions also reported the highest rates per 100,000 population -- 12.4, 11.7, and 8.9 respectively. The trend in the number of cases reported over the last 10 years is shown in Figure 12. The number of cases reported in 1994 declined sharply (29%) from those reported with onset in 1993 (453). In 1994 there were 3 outbreaks of shigellosis reported from 2 counties. The outbreaks occurred in 2 schools and 1 children's day care center, and resulted in 23 laboratory confirmed cases and an additional 6 epidemiologically linked cases.

The ratio of male to female cases was 0.92:1. The ratio of cases in whites compared to non-whites was 0.59:1; the race of 79 cases (24%) was unknown. Most cases occurred in young children. The highest rates per 100,000 population occurred in the birth to 4 year age group (21.7) and the 5-9 age group (22.7). One death occurred in an immunosuppressed patient infected with *S. dysenteriae*.

Of the 296 (92%) isolates for which the species was known, 211 (71%) were *S. sonnei*, 76 (26%) were *S. flexneri*, 7 (2%) were *S. boydii*, and 2 (<1%) were *S. dysenteriae*.

SYPHILIS, PRIMARY & SECONDARY (326)
6.5/100,000 (U.S. 7.8/100,000)

In 1994, the number of primary and secondary (P&S) syphilis cases decreased by 17% from 1993 (393 cases). Figure 13 shows the trend of P&S incidence in Maryland over the past 10 years. The number of cases in 1994 by jurisdiction is presented in Table 1 (see the July 1995 issue). Baltimore City* reported 59% of all cases, up from 46% of the statewide total reported in 1993. While the incidence rate in Baltimore City has remained relatively stable since 1990, the counties have experienced dramatic decreases.

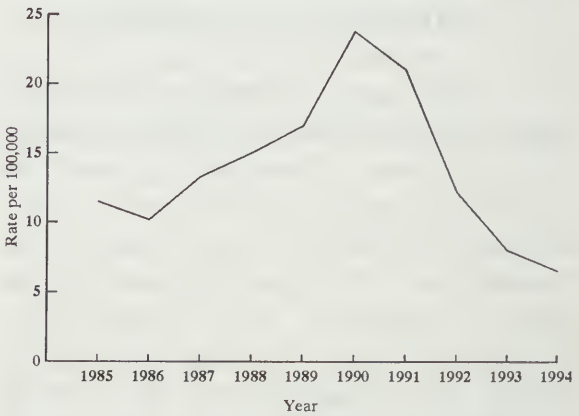


Fig 13. Primary and secondary syphilis. Incidence, Maryland, 1985-1994.

The ratio of male to female cases was 1.3 to 1. The race of 82% of the cases was specified as non-white. Sixty-one percent of the cases were 20 to 34 years old.

Since 1988 all P&S and early latent syphilis cases seen in public STD clinics have been offered HIV testing. The percent of co-infection in those tested has decreased each year, from 18% (66/372) in 1988 to 8% (33/411) in 1994.

The number of congenital syphilis cases (22) decreased 39% from 1993 (36). The following jurisdictions reported cases: Baltimore City (13), Prince George's County (6), Baltimore County (2), and Talbot County (1).

* Baltimore City data is provisional.

TUBERCULOSIS (363)
7.3/100,000 (U.S. 9.8/100,000)

The number of reported tuberculosis cases declined 13% from 1993 (417) to 1994 (363). The trend in reported cases since 1980 is seen in Figure 14. The number of cases in 1994 by jurisdiction is shown in Table 1 (see

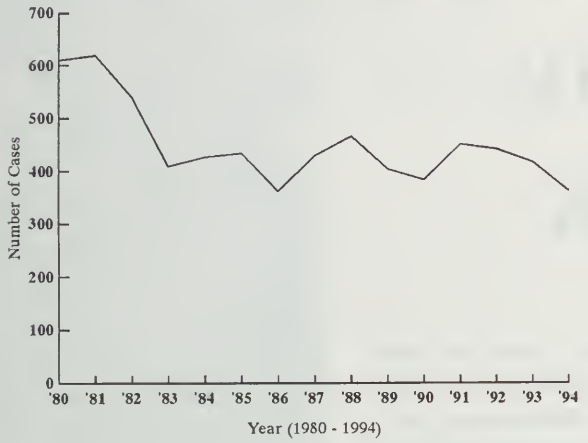


Fig 14. Tuberculosis. Cases reported, Maryland, 1980-1994.

the July 1995 issue) as is the State total for the previous 4 years. Baltimore City, and Montgomery and Prince George's Counties reported 29%, 22%, and 21%, respectively, of all cases in 1994. Most county's rates per 100,000 population decreased or remained stable from 1993; the Frederick County rate increased from 2.5 (4 cases) in 1993 to 5.8 (10 cases) in 1994.

The ratio of male to female cases was 1.5 to 1. Rates per 100,000 population were highest among Asians (rate 53.7, 75 cases), followed by Hispanics (rate 17.6, 22 cases), blacks (rate 13.7, 162 cases), and whites (rate 3.0, 99 cases). Rates increased progressively with increasing age, with the lowest among children age birth-14 years (1.8) and the highest rates occurring in those 65 years and older (21.6). Five percent (18 cases) were children under the age of 15 years and 31% (112 cases) were 65 years and older. Thirty-eight percent of all cases were foreign born.

A match of the tuberculosis and AIDS registries for 1994 identified 39 (10.7%) persons with both infectious diseases, compared to 41 (10%) in 1993, 60 (14%) in 1992, 36 (8%) in 1991, and 41 (11%) in 1990.

Drug resistance has not emerged as a significant problem in Maryland. In 1994, only 18 (5%) of the reported cases were isoniazid (INH) resistant, but not rifampin resistant, and 2 (0.6%) were resistant to at least INH and Rifampin. In 1994, three additional non-residents with tuberculosis resistant to at least INH and rifampin were identified and treated here.

Directly observed therapy (DOT), the observation by trained health care workers of every dose of medication taken, is a high priority public health strategy in Maryland. In 1994, 73% of patients diagnosed received DOT compared to 33% in 1992.

TYPHOID FEVER (14)
0.3/100,000 (U.S. 0.2/100,000)

Cases of typhoid fever were reported from Montgomery (4), Baltimore (3), Anne Arundel (2), Prince George's (2), and Howard (2) counties; and Baltimore City (1).

The ratio of male to female cases was 1.8:1. Six cases were Asian, 1 black, 1 white, 5 of other races, and 1 of unknown race. Ages ranged from 6 to 56 years (mean 29 years).

One case was due to laboratory exposure; 12 cases were acquired during international travel; and 1 case's source was unknown. Specific areas identified as travel sources included India (4), South America (2), Nigeria (1), and Pakistan (1).

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Cite SEER

Although cholera cases in the United States usually are associated with international travel, **consumption of contaminated food transported from other countries has been linked to four U.S. cholera outbreaks,** including one several years ago in Maryland linked to commercial frozen coconut milk imported from Thailand. The most recent outbreak reported to the Centers for Disease Control occurred in Indiana. Two of the four people who shared a meal that included food brought from El Salvador two days earlier had severe watery diarrhea and one had nausea and vomiting; in all four, vibriocidal antibody titers ≥649 (indicating recent infection with *Vibrio cholerae* 01) were detected. Health care providers initially did not suspect cholera because the patients had no history of recent travel; in one patient, stool cultures obtained on two occasions three days apart were negative for bacterial pathogens, but were not cultured specifically for *V. cholerae*. **Patients with severe diarrhea or suspected cholera should be asked about recent travel and consumption of foods transported from another country.** Stool samples in such patients should be cultured on thiosulfate-citrate-bile salts-sucrose agar, because other media routinely used for stool cultures may not support the growth of *V. cholerae* (*MMWR Morb Mortal Wkly Rep* 1995;44:385–386).

Data from a national survey of 17,592 students at 140 American colleges conducted by researchers at the Harvard School of Public Health (*Am J Public Health* 1995;85:921-926) indicate that 50% of the men and 39% of the women binge drink (defined as 5 or more drinks in a row for men and 4 or more drinks in a row for women). **The strongest predictors of binge drinking among U.S. college students may be residence in a fraternity or sorority, adoption of a party-centered lifestyle, and engagement in other risky behaviors such as using marijuana and smoking cigarettes.** Other predictors include being white, age below 24, binge drinking during the last year of high school, considering religion unimportant, strongly valuing athletics, and having more than two sex partners in a month. Survey factors not predictive of binging include time spent watching television or videos, year in college (binge rates were almost identical across the different years in college), and legal minimum drinking age of 21.

Results of a retrospective case study involving 17 patients with known or suspected **cough due to angiotensin-converting enzyme (ACE) inhibitors** (*Arch Fam Med* 1995;4:525–528) indicate that this side effect **may be associated with misdiagnosis, delay in diagnosis, and prescription of ineffective, empirical treatment**. There was a delay of 2 to 56 weeks (average, 14.5 weeks) between initiation of ACE inhibitor treatment and documentation in the medical record of the complaint of cough (the cough develops over weeks); and a delay of 3 to 91 weeks (average, 24 weeks) between treatment initiation and attribution of the cough to the ACE inhibitor or treatment discontinuation. Alternative diagnoses included infections, atopic illness, obstructive airway disease, and gastroesophageal reflux. Prescribed treatments included antibiotics, cough suppressants, decongestants, antihistamines, an inhaled beta-agonist, and metoclopramide hydrochloride, all of which were ineffective. The authors conclude that attention to careful history taking and recognition that chronic cough may be a side effect of ACE inhibitors would solve the diagnostic problem and that early identification would reduce unnecessary prescriptions and diagnostic testing.

Cite SEER

To study the relationship between exertional symptoms, ventilatory and skeletal muscle dysfunction, and circulatory function **in ambulatory patients with heart failure,** Vanderbilt University Medical Center investigators (*Circulation* 1995;92:47-53) monitored hemodynamic responses to maximal treadmill exercise and concurrently asked the patients to quantify their level of exertional fatigue and dyspnea according to a standardized scoring scale. Study results indicate that the patients' **perceived level of exercise intolerance has little or no relation to objective measures of circulatory, ventilatory, or metabolic dysfunction during exercise.** Cautioning that exertional symptoms may be related to muscle deconditioning, obesity, and other noncardiac factors, the authors suggest that physicians no longer rely solely on pharmaceutical interventions to treat these symptoms. The authors also caution that absence of exertional symptoms should not be considered definite evidence that cardiac function is preserved.

A large-scale epidemiologic study of the prevalence and consequences of drug-induced extrapyramidal symptoms among elderly patients in or out of institutions (*Am J Med* 1995;99:48-54) indicates that **neuroleptic drugs are a common cause of extrapyramidal dysfunction in patients aged 65 to 99 and that anticholinergic or dopaminergic drugs are frequently used to manage iatrogenic parkinsonism.** The study compared 3512 Medicaid participants who were first-time users of an antiparkinson drug with 16 437 case control subjects who had not been prescribed antiparkinson medication. Investigators then evaluated the use of neuroleptic drugs in the 90 days before and after the initiation of antiparkinson treatment. Patients given neuroleptics were 5.4 times more likely to begin antiparkinson medication and had a greater than two-fold increase in risk of being given a dopaminergic drug. The authors thus speculate that neuroleptic side effects may often be mistaken for idiopathic Parkinson's disease in the elderly, resulting in inappropriate symptom management.

Until recently, group C rotaviruses, which are a recognized cause of gastroenteritis in children and adults in many countries and may be associated with extrahepatic biliary atresia, **have not been identified from patients in the United States.** As part of an ongoing prospective study of the etiology of diarrhea among hospitalized children, investigators screened for group C rotavirus from specimens that were positive for rotavirus by electron microscopy, but negative for group A rotavirus by enzyme-linked immunoabsorbent assay (ELISA). Of 16 specimens examined, 3 were positive for group C rotavirus by ELISA using reagents specific to the Cowden strain of porcine group C rotavirus and all 16 were positive by reverse transcriptase-polymerase chain reaction. The infections occurred primarily in infants aged less than 1 year. Stating that their findings indicate **group C rotaviruses are more common than previously thought and** demonstrate for the first time that **these agents are present in fecal specimens from children with diarrheal illnesses in the United States,** the authors urge development of simpler, more sensitive assays for detecting the virus in clinical specimens (*J Infect Dis* 1995;172:45-50).

Results of a 6-week, randomized, double-blind, parallel-group study comparing the efficacy and safety of fluoxetine (Prozac) and sertraline (Zoloft) in 286 outpatients with major depression or bipolar disorder (depressed) indicate that both antidepressants are equally effective and well tolerated (*J Clin Psychiatry* 1995;56:229-237). Study results also confirm that the dosing strategy with selective serotonin uptake inhibitor antidepressants differs from that traditionally used with tricyclic antidepressants (TCAs). Whereas TCAs are started at a low daily dose that is gradually increased to the highest daily dose tolerated by the patient, the starting dose with fluoxetine and sertraline may also be the final dose. In the current study, only 24% of patients required doses higher than the starting dose (sertraline 50 mg/day or fluoxetine 20 mg/day).



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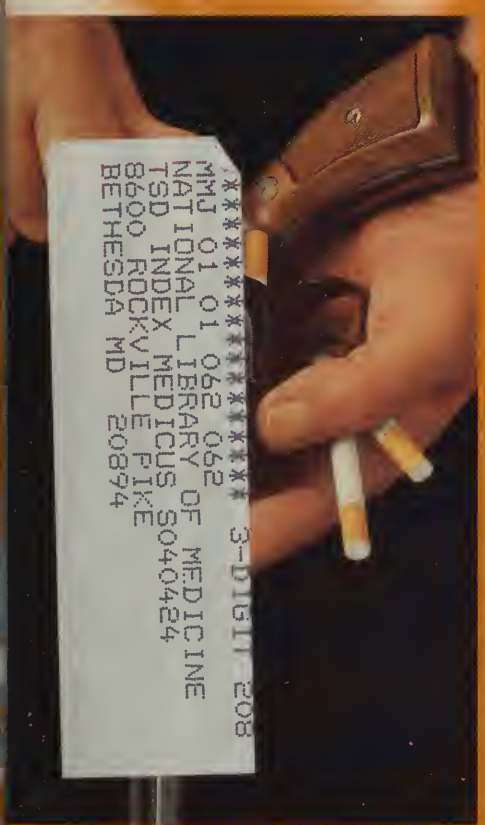
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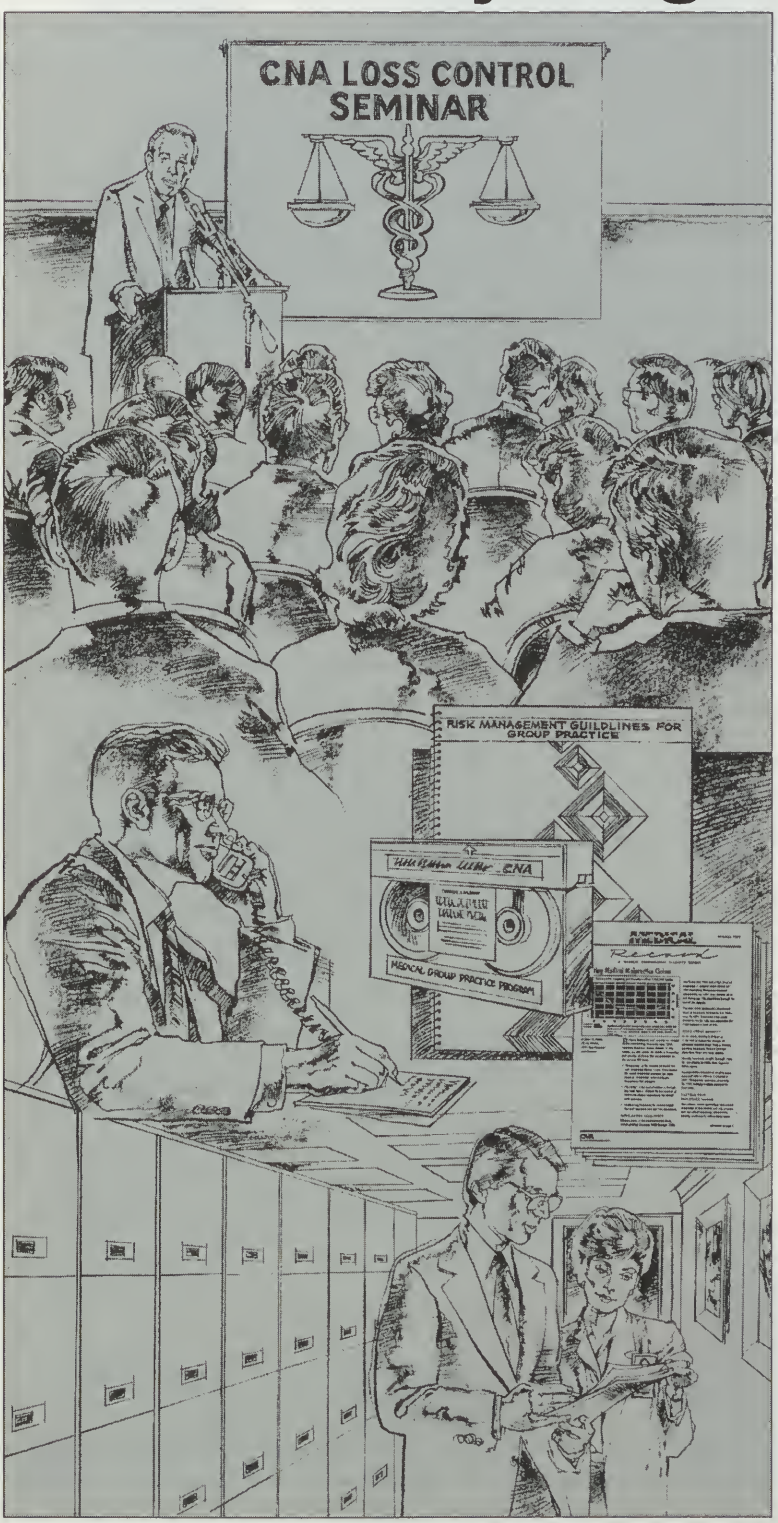
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3. Canadian Cancer Society publication # 219107.

4. From "Spitting into the Wind: The Facts about Dip and Chew." U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health. NIH Publication 94-3880, December 1994.

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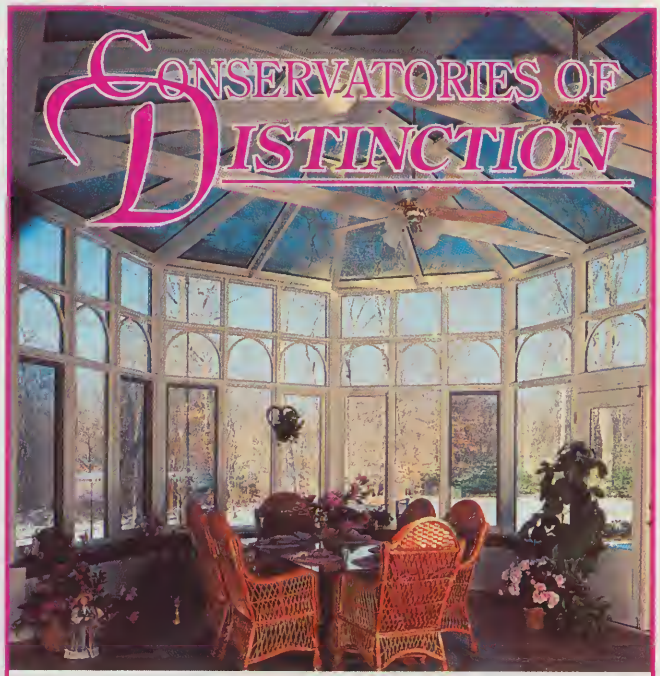
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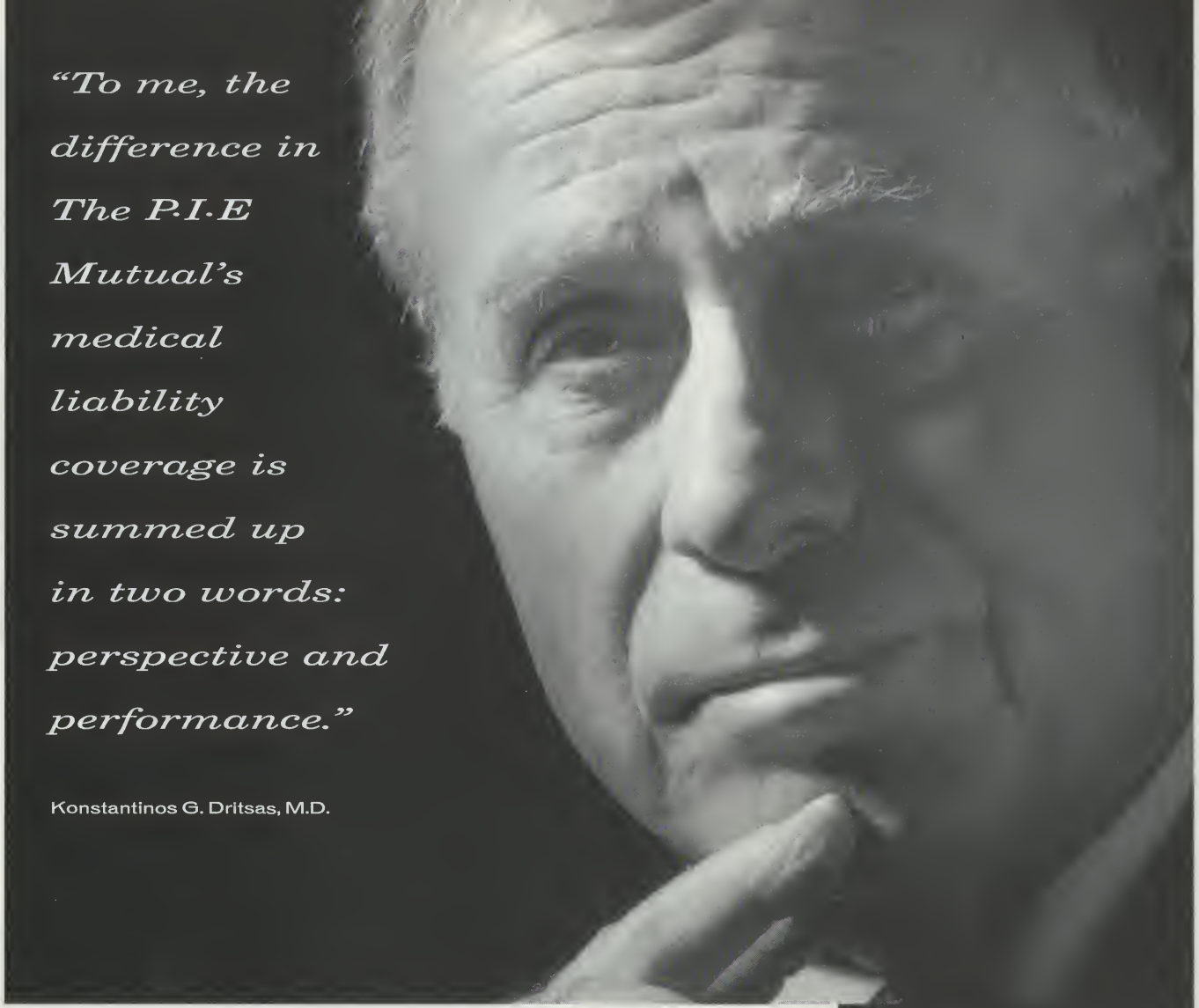
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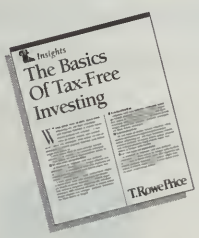
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Call to Action — GME Medicare Spending Cuts

The American Medical Association (AMA) is urging physicians and medical students to contact U.S. Representatives and Senators to oppose the proposed reductions of up to 50% in Medicare Graduate Medical Education (GME) payments. Although the AMA expects some reductions in the Medicare Direct and Indirect payment formulas, it is opposed to the severe and swift cuts along the lines proposed by Rep. Nancy Johnson (R-CT).

The cuts currently proposed could translate to appreciable cuts in faculty and specialty program slots, decreased pay for resident physicians, and an overall drop in the quality of education for residents and health care services for our patients.

Write or call the Capitol switchboard at 202-224-3121 and ask for your representative or senator by name and state and express your opinions. Provide personal information on the effect of large, immediate, across-the-board GME cuts on your patients, your area's health system, your teaching facility, and the surrounding economy. Express support for more gradual reductions along the lines proposed by the AMA.

Source: AMA Network

HCFA Update

Effective July 11, 1995, the Health Care Finance Administration (HCFA) is no longer requiring physician attestation verifying the diagnosis and procedures performed during a hospital stay to process Medicare hospital claims. The White House feels this will save an average hospital $22,500 in administrative costs and 200,000 hours of physician time. Although no official notification will be sent to providers concerning this change, it will be published in the Federal Register.

Source: Direct Connection, Volume 95, Issue 18, July 28, 1995, Ernst & Young LLP

Med Chi Awards for Excellence in Medical Journalism Announced

The following were selected to receive the 1994-1995 Med Chi Awards for Excellence in Medical Journalism:

Video

First Place:
"Matter of the Heart"
Lisa Willis
WBFF-TV (Fox 45)

Second Place:
"Scoliosis Recovery"
Bill Seiler
WMAR-TV (First at Five)

Daily Newspapers

First Place:
"The Abuse of Antibiotics"
David Brown and Kathleen Day
The Washington Post

Second Place:
"Prostate Health"
Linnell Smith
The Sun

Magazines and Nondaily Newspapers

First Place:
"Healing the Scars Within"
Lynne Salisbury
Howard County Times

Second Place:
"One Man's Struggle"
Diane Brown
Columbia Flier

Radio
First Place:
"Menopause"
John Stupak
Consultation Radio Network

Med Chi is making a $500 donation to the charities designated by each of the first place winners. The charities chosen were:

Lisa Willis—Easter Seal Society
Lynne Salisbury—Mid-Atlantic Burn Camp
John Stupak—Baltimore Wellness Community (a cancer support organization)

Copies of the winning articles may be obtained by calling Ruth Seaby, Communications Director, at 410-539-0872 or 800-492-1056, ext. 340.

MMJ Best Article Award

During the 1995 Semiannual Meeting, the *Maryland Medical Journal* announced the winner of the ninth annual Best Article Award for the most outstanding article published during 1994. F. Michael Gloth, III, M.D., won for "Hospice: the most important thing you didn't learn in medical school," which was published in June 1994.

Med Chi Seeks Physicians for Sunday Rounds *Program*

Sunday Rounds is a weekly radio program, hosted by John Stupak and sponsored by Med Chi, that airs on WBJC (91.5 FM) from 7:00 p.m. - 8:00 p.m., Sunday evenings. Med Chi physicians are invited to participate in the program, which is aimed at providing the public with information on current health topics. Scheduling for 1996 has now begun. If you are interested in being a guest on *Sunday Rounds*, please call Heather Johnson at 410-539-0872 or 800-492-1056, ext. 306.

Study Group in Alternative Medicine

The next meeting of the Study Group in Alternative Medicine will be held Wednesday, October 18, 1995, at 6:30 p.m., at Med Chi. A business meeting for the Study Group will be conducted from 6:30 p.m. - 7:00 p.m. From 7:00 p.m. - 9:00 p.m., Xie Zhu-Fan, M.D., Professor of Medicine, Beijing (Peking) Medical University, will discuss the integration of traditional Chinese medicine and Western medicine. Those wishing to attend Dr. Xie's program must pay a fee of $60 ($30 for medical school students), which will be collected at the beginning of his program.

Please call Steve Jones at Med Chi at 410-539-0872 or 1-800-492-1056, or Hiroshi Nakazawa, M.D., at 410-644-1502 if you wish to attend or have questions regarding the study group. Light refreshments will be served.

Essay Contest

The Med Chi Bicentennial Committee will sponsor an essay contest for all middle and high school students this fall. The subject will be the health hazards posed by tobacco use. Winners will be selected, and appropriate awards made, by representatives from the Coalition for a SmokeFree Maryland, the *Maryland Medical Journal*, and the Public Health, Public Relations, and Bicentennial committees. An announcement will be made when the contest begins and it is hoped that all Med Chi members will encourage and inspire young people in their communities to participate.

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President's Letter

Prepared by the President of the Medical and Chirurgical Faculty of Maryland as a service to members

Dear Colleague:

This special issue of the *Maryland Medical Journal* offers physicians compelling information on the magnitude of the tobacco use problem among Maryland youth, as well as actions we can take in our practices and our communities to reduce tobacco-related illness and death. Recently, Maryland has made significant strides toward building a healthier state by creating smoke-free environments for 95% of the workforce. The involvement of physicians from across the state was crucial to the passage of these protections.

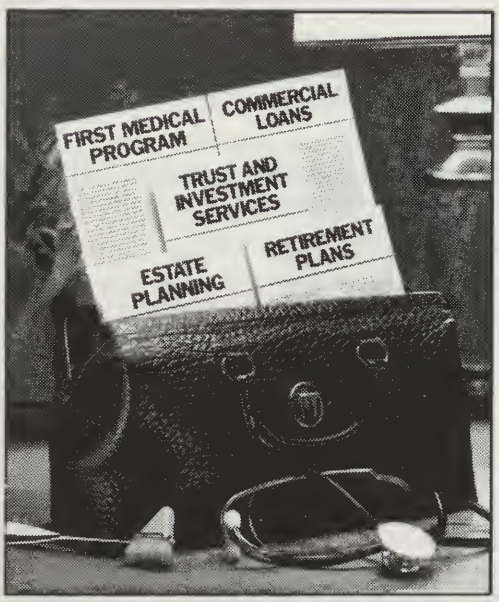
When it comes to protecting children from tobacco addiction, however, Maryland's record is not impressive. Although it has been illegal to sell tobacco to minors for over one hundred years in our state, more than 10 million packs of cigarettes continue to be sold illegally to Maryland youth each year. Tragically, most of the 7,000 Marylanders who die of tobacco-related disease annually became addicted as children.

Fortunately, as physicians we have at least two avenues through which to make an impact on the problem of youth addiction and tobacco-related illness. The first, and perhaps the most obvious, is with our patients. Providing patients who smoke with the treatment, encouragement, counseling, and resources they need to quit can greatly increase their chances for a lifetime of better health. For our younger patients, we must take every opportunity to discourage the initiation of smoking. Secondly, we can have an impact by acting as advocates for change. In our communities, before the legislature, by writing and speaking out, we can share our firsthand knowledge and experience of the very real devastation tobacco causes in those who are unfortunate enough to be addicted. Some physicians in the state have successfully joined forces with patients to work for changes that would ultimately benefit all Marylanders, such as the creation of smoke-free schools and workplaces. There is no reason we cannot also be successful in combating what are now our most intransigent problems: the continued escalation of tobacco use among youth and the continued illegal sale of tobacco to minors.

Please use the information in this journal to expand your understanding of the problem and to increase your involvement in efforts to prevent and reduce tobacco addiction and its related diseases. If you are interested in learning about current tobacco use prevention activities in Maryland, or would like prevention or cessation materials, contact the Smoke Free Maryland Coalition at Med Chi at 410-539-0872 or 800- 492-1056.

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Cautious optimism: will we ever see a tobacco-free generation?

Those concerned with public health must remain vigilant—always watching for changes in health status and ready to intervene when needed. At first glance, it appears that we are winning the war on tobacco use and exposure to environmental tobacco smoke (ETS). During the past ten years, adult smoking prevalence in Maryland dropped from 29% to a level hovering around 20%. Adults appear to be taking the tobacco use prevention message to heart. Thousands of Marylanders have quit smoking. Our middle school students are participating in classes to help demystify tobacco use and tobacco industry advertising. Most workplaces are now smoke free due to the regulations implemented by Maryland Occupational Safety and Health (MOSH) and statutory requirements signed into law by Governor Parris Glendening. We should be truly proud.

The October 1995 issue of the *Epidemiology and Disease Control Newsletter* reviews the growing tobacco use problem in Maryland. Although we have made progress, tobacco still takes the lives of more than 7,500 Marylanders each year. No consumer product available to the general public causes as much death and disease as tobacco. In fact, tobacco products are the only consumer goods which are lethal to the customer when used as directed. The decisions we make and the actions we take to solve the tobacco use problem will greatly affect the future of Maryland. We must, therefore, analyze the past and prepare for the future if we are to make Maryland the Free State—free of tobacco-caused disease and death. The following indicators demonstrate why we should be concerned:

- From 1988 to 1992, Maryland youth in all grades increased their cigarette and smokeless tobacco use.[1] About one of three Maryland young people now regularly smokes. Because early initiation of tobacco use leads to early addiction, we should be concerned that smoking among 6th graders is rising. By the time these children become seniors in high school, most of them will have become addicted and will suffer the same withdrawal symptoms as adults should they attempt to quit. As a result of the addiction process, many of these young people will continue to smoke throughout their lifetime.[2] Recent studies also confirm that youth smokers tend to make more unhealthy lifestyle choices than their counterparts who never smoke.[3,4] Young smokers are much more likely than those who never smoke to binge drink, use marijuana and cocaine, and carry a weapon.[3] Unhealthy behaviors like these lead to a lifetime of medical and social problems as well as increased personal and public health care costs.
- Since the last cigarette excise tax increase (May 1, 1992), there has been no significant decline in the overall smoking prevalence in Maryland.[1]
- More people are dying from tobacco-caused disease.[1] The Department estimates that at least 6,700 deaths in Maryland were attributable to smoking in 1993. An

Speak Out

additional 1,000 deaths in 1993 were due to passive exposure to ETS. A growing population, stagnant adult smoking prevalence, and an increase in smoking prevalence among young people will lead to future increases in death and disease.

- For years, there has been a decrease in the smoking-attributable years of potential life lost (YPLL) for both men and women. In recent years, however, YPLL for women has been decreasing at a slower pace than men's.[1] Women who smoke are dying at earlier ages, mostly due to smoking-caused lung cancer. That trend is most likely due to growing female smoking prevalence during the 1960's.
- For the past 40 years, Maryland has had higher cancer death rates than the rest of the country[5]. This is due, in part, to our State's high lung cancer mortality rate. A recent report released by the Maryland Cancer Registry indicated that lung cancer is the second most common cancer in Maryland -- accounting for 15 percent of all cancer cases. It is also the most lethal of all cancers. Tobacco use appears to be the major cause of the lung cancer problem in Maryland.[6]
- The Maryland Occupational Safety and Health regulation eliminating ETS from most enclosed workplaces was a major step in protecting the public health of Marylanders. This regulation will go a long way to reduce the 1,000 yearly deaths caused by ETS exposure in Maryland. Our hospitality workers, however, are still at risk. In fact, the level of ETS in restaurants and bars is two to six times the amount found in most office workplaces. As a result, those who work in bars and restaurants have an excess lung cancer risk of at least 50%.[7] We must strive to protect all workers from ETS and convince adults not to smoke around children in enclosed areas if we are to prevent illness, disease, and death caused by ETS exposure.
- The cost of smoking to the Maryland economy is increasing.[1] For 1993 alone, we estimate that these costs exceeded 1.5 billion dollars in both direct and indirect mortality and morbidity. These estimates are conservative: our calculations do not include smoking-attributable costs related to ETS, fire, and prenatal deaths and injuries.

Perhaps more than any time in history, Maryland is suffering from the effects of tobacco use, whether it be cancer, heart disease or a host of other smoking-caused diseases. Our citizens are dying as a direct result of several decades of tobacco use and exposure to ETS. Our economy is also suffering as a result. If we do not address each of the issues raised above, future generations of Marylanders will pay the price. As more young people become addicted to tobacco, we can expect higher adult tobacco use prevalence, more death and disease, and spiraling economic costs in the future.

We can do something about these problems if we all work together. President Clinton recently took a courageous step to protect young people from tobacco addiction. The FDA has been given permission to begin regulatory steps that will most assuredly help to reduce the youth tobacco use problem in the United States.[8] The proposed rules will reduce youth access to tobacco by 1) requiring age verification and face-to-face tobacco sales; 2) eliminating mail-order sales, free samples, sale of single cigarettes (loosies), and packages with fewer than 20 cigarettes; and 3) eliminating tobacco product vending machines and self-service displays. Tobacco advertising targeted to youth will be quelled by banning outdoor advertising within 1,000 feet of schools and playgrounds; requiring black and white, text-only advertising on outdoor advertising (including bus and billboard ads), on all point-of-purchase advertising and in publications with more than 15% youth readership or 2 million youth readers; prohibiting the sale or give-away of products like caps or gym bags that carry brand names or logos; allowing corporate name sponsorship of sporting or entertainment events while prohibiting brand name sponsorship; and requiring the industry to fund a public education campaign to prevent kids from smoking.

Although localities and many states are actively pursuing tobacco use prevention goals, they simply cannot match the widespread protective power of federal action. Increasing federal oversight of tobacco products will guarantee equal protection for our children and assure a healthier future for all Americans. Although federal action appears to be forthcoming, it could take several years before we see any concrete action. We must, therefore, continue to work at the state and local levels to assure quick, strong, and effective protection for our young people.

Passing strong and sensible tobacco use prevention laws must be our first step. Last year, the attorney general and I supported legislation to reduce youth access to tobacco. That law would have allowed the local health departments in cooperation with local law enforcement to closely monitor the illegal sale of tobacco to minors. By also limiting the placement of tobacco vending machines to adult accessible locations and holding merchants accountable for repeatedly selling tobacco products to youth, we would have seen a decrease in youth smoking rates. Unfortunately, the tobacco industry claimed yet another victory by defeating this bill. Whether we work to reduce youth access to tobacco, propose reasonable standards for tobacco advertisers, or introduce local ordinances to protect hospitality workers from ETS, the support of the medical community is crucial.

Practicing physicians can have a large impact on public policy. Even a small amount of time and effort on your part can yield significant results. Let your lawmakers at every level know how you feel about our tobacco use

Speak Out

problem. Describe to them how stronger, more protective laws will help solve the problem. Talk to your patients, family and friends letting them know of your concerns regarding youth tobacco use. Encourage them not to smoke around children, especially in enclosed areas. Send a quick letter-to-the-editor to your local newspaper calling for tougher enforcement of youth access to tobacco laws. Persuade your patients to quit smoking and help them to succeed. If you have more time, get involved with local tobacco use prevention coalitions working for change in your community.

Changing public policy has always been the first step in controlling a major public health threat. Tobacco use is clearly a major threat to our children's health and welfare. What further evidence do we need? The Department of Health and Mental Hygiene will continue to work for changes in public policy that will protect both young people from nicotine addiction and the general public from exposure to ETS. The medical community must help if we are to succeed. Are you willing to lend a hand?

MARTIN P. WASSERMAN, M.D., J.D.
Secretary, Maryland Department of Health and Mental Hygiene

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7. Siegel M. Involuntary smoking in the restaurant workplace: a review of employee exposure and health effects. *JAMA* 1993;270:490–493.
8. 60 Federal Register, p 41314 (August 11, 1995). ■

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Growth & Income	★★★★	★★★★	★★★★	★★★
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Mid-Cap Growth	★★★★★	★★★★★	–	–
New America Growth	★★★★	★★★★	★★★★	–
New Era	★★★	★★★★	★★	★★★
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Kenneth P. Johnson, M.D., head of the department of neurology at the University of Maryland Medical Center, is the lead author of a report on a multi-center, double-blind, placebo-controlled phase III trial of copolymer 1 (Copaxone) in patients with relapsing-remitting multiple sclerosis. Results, published in *Neurology* (1995;45:1268–1276), indicate copolymer 1 may significantly reduce relapse and disability in some MS patients. **Hillel S. Panitch, M.D.,** a professor of neurology at the University of Maryland Medical Center, is among the co-authors.

Charles J. Yeo, M.D., and **John L. Cameron, M.D.,** are among the authors of a study of the radiographic appearance of a pancreatic-ogastrostomy (PG) and its complications. They report that PG caused a gastric filling defect in most of the patients studied and that clinical findings of delayed gastric emptying do not correlate with upper gastrointestinal series findings (*Radiology* 1995;196:251–255). Dr. Yeo is an associate professor of surgery and Dr. Cameron is director of surgery at The Johns Hopkins University School of Medicine.

Douglas E. Mattox, M.D., Michael J. Holliday, M.D., and **John K. Niparko, M.D.,** are among the authors of a study indicating that in the acute stage after resection of acoustic neuroma, vestibular adaptation exercises improve postural stability and diminish patients' perceptions of dysequilibrium (*Otolaryngol Head Neck Surg* 1995;113:77–87). Dr. Mattox is professor and vice chairman of the department of otolaryngology-head and neck surgery and director of the division of otology at The Johns Hopkins University School of Medicine. Dr. Holliday is an assistant professor and Dr. Niparko is an associate professor of otolaryngology-head and neck surgery at Hopkins.

Patricia A. Thomas, M.D., and **Nancy Ryan Lowitt, M.D.,** are the authors of the clinical problem-solving section in the August 3 issue of the *New England Journal of Medicine* (1995;333:307–310). The case describes a patient with a previously unknown history of domestic violence who presented with stroke. Dr. Thomas is an assistant professor of medicine at The Johns Hopkins University School of Medicine. Dr. Lowitt is associate director of the general internal medicine residency program at Johns Hopkins Bayview Medical Center.

Ahvie Herskowitz, M.D., and **Noel R. Rose, M.D., M.P.H.,** are among the authors of a study of the effects of immunosuppressive therapy (prednisone plus cyclosporine or azathioprine) on left ventricular function in patients with myocarditis. Results indicate immunosuppressive therapy is not beneficial in most patients with histologically-confirmed myocarditis (*N Engl J Med* 1995;333:269–275). Dr. Herskowitz is an assistant professor of medicine, immunology, and infectious diseases and Dr. Rose is a professor of microbiology and immunology at The Johns Hopkins University School of Medicine.

Barbara Starfield, M.D., M.P.H., a professor of health policy and management and head of the division of health at The Johns Hopkins University School of Hygiene and Public Health, is the author of an invited commentary (*JAMA* 1995;274:346–347) on the lead article for that issue, a study of hospitalization rates and access to health care (*JAMA* 1995;274:305–311).

Carol Carraccio, M.D., of the department of pediatrics at the University of Maryland Medical Center, and **Krystyna Blotny, M.D.,** of the department of pediatrics at Johns Hopkins Bayview Medical Center, are coauthors of a chart review study (*Pediatrics* 1995;96:48–51) to determine the applicability of standards for normal cerebrospinal fluid (CSF) to children with systemic illness but without central nervous system infection.

Laurence Udoff, M.D., Patricia Langenberg, Ph.D., and **Eli Y. Adashi, M.D.,** are the authors of a review article evaluating the putative benefits of combined continuous hormone replacement therapy for postmenopausal women (*Obstet Gynecol* 1995;86:306–316). Dr. Udoff is a fellow in reproductive endocrinology, Dr. Langenberg is a professor of epidemiology, and Dr. Adashi is a professor of obstetrics/gynecology and physiology and the director of reproductive endocrinology at University of Maryland Medical Center.

Lisa B. Dixon, M.D., of the Center for Mental Health Services Research at University of Maryland Medical Center, is the lead author of an article describing a program in Baltimore that has adapted the Program for Assistive Community Treatment (PACT) to serve homeless people with severe mental illness (*Psychiatric Services* 1995;46: 684–688). **Anthony F. Lehman, M.D., M.S.P.H.,** a professor of psychiatry at University of Maryland, is among the coauthors.

John P. Gearhart, M.D., and **Robert D. Jeffs, M.D.,** are among the authors of a report indicating that in boys aged 1.5 to 18 years with exstrophy or epispadias, the Cantwell-Ransley epispadias repair offers a straighter urethra and penis, better correction of chordee and cosmesis, and a lower fistula rate than the Young urethroplasty (*Urology* 1995;46:92–95). Dr. Gearhart is director of pediatric urology and an associate professor of urology and Dr. Jeffs is a professor of urology and pediatrics at The Johns Hopkins University School of Medicine.

Bert M. Glaser, M.D., of the Retina Institute of Maryland in Baltimore, is among the authors of a study of the fluorescein angiographic characteristics in eyes with pseudoholes of the macula associated with epiretinal membranes. They conclude that early hyperfluorescence within the area of the pseudohole may result in misdiagnosis of the macular pseudohole as a full-thickness macular hole (*Ophthalmology* 1995;102:768–774).

Herbert Chen, M.D., Theresa L. Nicol, M.D., and **Robert Udelsman, M.D.,** are the authors of a chart review study of 125 consecutive patients with follicular thyroid lesions in whom frozen section evaluation was performed at the time of surgical exploration. In 104 patients (87%), frozen section evaluation rendered no useful clinical information (*Ann Surg* 1995;222:101–106). Dr. Chen is an assistant resident in surgery, Dr. Nicol is a clinical fellow in pathology, and Dr. Udelsman is director of endocrine surgery at The Johns Hopkins University School of Medicine.

Steven J. Kittner, M.D., M.P.H., associate professor of neurology at University of Maryland Medical Center, is among the authors of a prospective study to determine whether a low serum folate concentration is associated with ischemic stroke. Results suggest that a folate concentration $\leq$9.2nmol/L may be a risk factor, especially in blacks (*Stroke* 1995:26:1166–1170).

Catherine A. Marco, M.D., of the department of emergency medicine at Johns Hopkins Bayview Medical Center, is the lead author of a study (*Ann Emerg Med* 1995;26:18–24) indicating that in elderly patients, fever alone, even in the absence of other abnormal signs, may indicate the presence of serious illness (e.g., pneumonia, urinary tract infection, sepsis). Dr. Marco's coauthors are **Gabor Kelen, M.D., Charles N. Schoenfeld, M.D., Karen N. Hansen, M.D., David A. Hexter, M.D.,** and **Dana A. Stearns, M.D.,** all of The Johns Hopkins Medical Institutions.

John S. Dumler, M.D., an associate professor of pathology at University of Maryland Medical Center, is coauthor of a report describing two human ehrlichioses as emerging zoonotic infections (ticks are the likely vectors) in the United States. Characterized by undifferentiated fever with leukopenia, thrombocytopenia, and elevations in serum aminotransferase levels, they respond well to doxycycline (*Clin Infect Dis* 1995;20:1102-1110).

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  Vie, September 1995

- "Do Bras Cause Breast Cancer?"
  New Age, August 1995

- "Lose Stubborn Pounds (You May Need Extra Calories)"
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- "Simple Test For Colon Cancer"
  **Cosmopolitan,* September 1995

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  Parents, September 1995

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  Scientific American, September/October 1995

- "Eat More. Lose Weight. 6 Ways to Burn Fat Faster"
  **McCalls,* September 1995

- "Big Fat Lies. Separating Nutrition Fact From Fiction"
  Women's Sports & Fitness, September 1995

- "It's NOT Stress. Women's Diseases Doctors Ignore"
  **Ladies' Home Journal*, September 1995

- "20th Century Blues. Stress, Anxiety, Depression: The New Science of Evolutionary Psychology Finds the Roots of Modern Maladies in Genes"
  **Time,* August 28, 1995

- "I Want to Live" (bone marrow transplant)
  Washingtonian, August 1995

- "Jews and Organ Donations. All Take and No Give?"
  Moment, September 1995

- "Are Harmless Drugs Sabotaging Your Sex Life?"
  **Cosmopolitan,* September 1995

- "Is Estrogen Safe for *You*? How to Know"
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- "The Great Breast Implant Hoax: How Silicon Was Bad Rapped"
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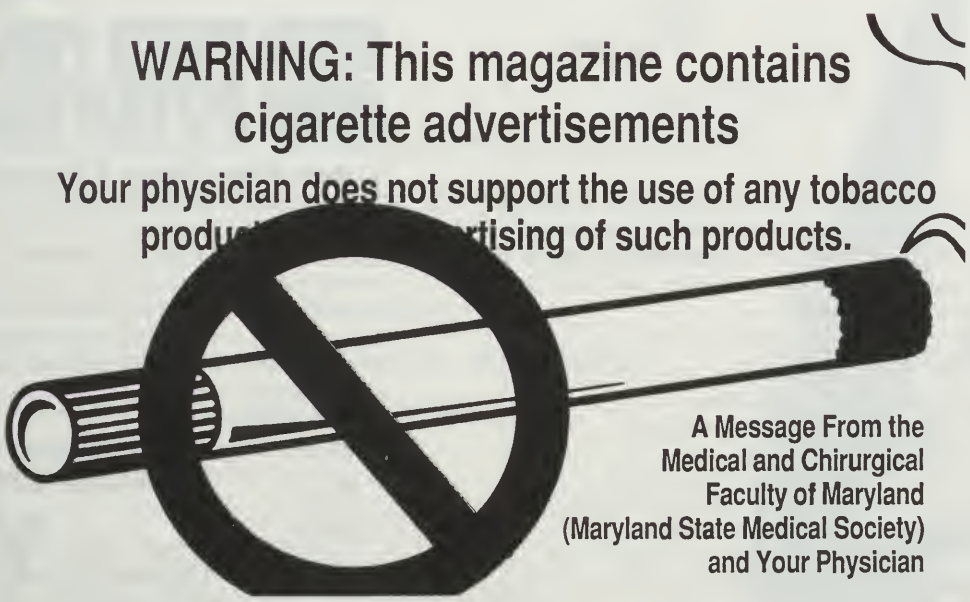
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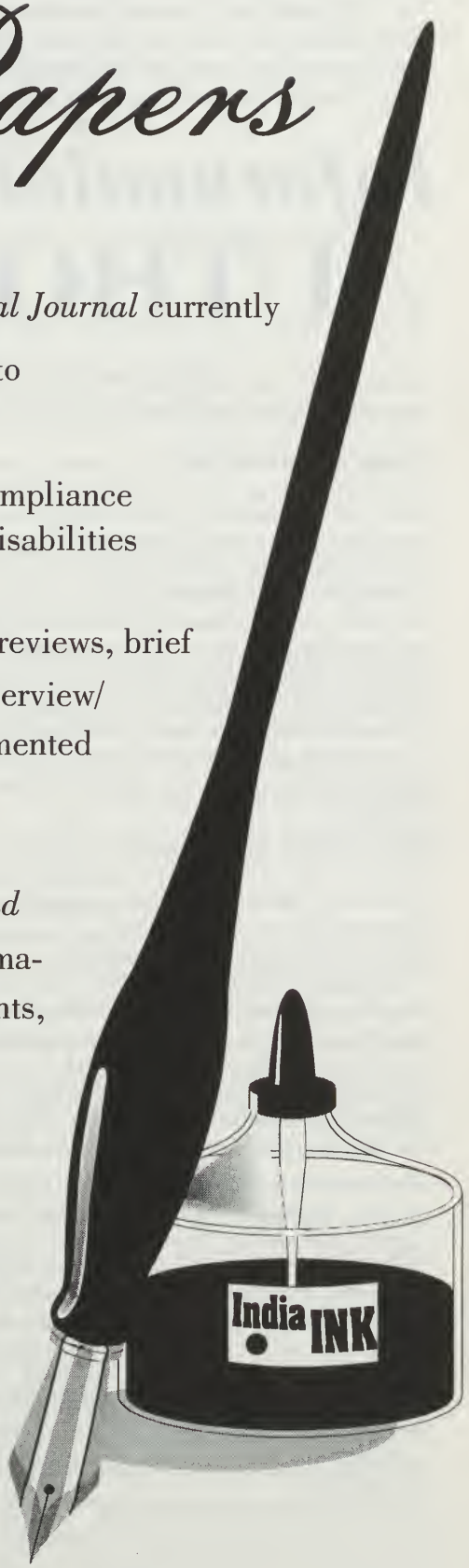
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Marketing adolescent tobacco addiction

Joe Tye, M.A., David G. Altman, Ph.D., and Joseph R. DiFranza, M.D.

Mr. Tye is the founder of STAT (Stop Teenage Addiction to Tobacco). Dr. Altman is an associate professor in the department of public health at The Bowman Gray School of Medicine in Winston-Salem, North Carolina. Dr. DiFranza is a member of the department of family practice at the University of Massachusetts in Worcester.

The epidemic of tobacco-induced disease continues, and tomorrow's victims can be seen on many street corners wearing Joe Camel baseball caps and Marlboro T-shirts.

Each year, approximately 3 million children and teenagers under the age of 18 smoke nearly 1 billion packs of cigarettes, worth more than $1.25 billion at retail.[1] From the perspective of the tobacco companies, addicting children and teenagers to tobacco is more than a means of creating short-term profits. Young people are the replacement smokers needed for the nearly two million adults who quit smoking or die each year.[2]

Although they deny doing it, tobacco companies and their advertising agencies carefully and deliberately craft sophisticated marketing campaigns that encourage children and teenagers to experiment with, and become addicted to, tobacco. In 1993, tobacco companies spent more than $6 billion promoting addiction; that equates to nearly $700,000 per hour, 24 hours per day, every day of the year. This deluge of marketing firepower has created, in the words of Food and Drug Administration commissioner Dr. David Kessler, "a pediatric disease," since virtually all new smokers come from the ranks of our children.

Tobacco and marketing executives claim that they do not want children to smoke, and that their promotional expenditures do not target or influence anyone under the age of 21, even though almost all smokers begin before that age and establish their brand loyalties very early. They say that the only effect of their marketing is to encourage brand-switching among current smokers. These are, however, the same people who deny that nicotine is addictive, that smoking has been proven to cause disease, or that it is harmful for nonsmokers to inhale environmental tobacco smoke. Advocates for health, on the other hand, argue that tobacco marketing does increase tobacco use, especially among young

people. A growing body of research supports that position, as summarized in the 1994 report of the Surgeon General.[3]

The BS theory of cigarette advertising and promotion

In 1993, the last year for which data are available, the tobacco industry spent $6.03 billion on advertising and promotion.[4] Industry executives claim that the only purpose and the only result of all that advertising and promotion is to influence the brand preference of current adult smokers. Let's call it the brand switching, or BS, theory. A simple analysis shows that would be economically irrational. Fewer than 10% of all smokers switch brands each year,[5] and many of those switches are within the brand families of a single company (a smoker who switches from Winston to Camel to Vantage to Now, all RJR Nabisco products, does not add a customer to that company).

In 1993, the industry spent approximately $1,400 in advertising and promotion for every smoker who switched brands. That amount is actually understated because it does not include the cost of corporate salaries and overhead devoted to marketing. A pack-a-day smoker generates less than $150 in net profits. Thus, the potential incremental profit generated by all brand-switchers accounts for only about 10% of the marketing investment made for each smoker who switches brands. The only viable economic rationale for this level of expenditure is that cigarette companies view it as an investment in future sales, generated by attracting new smokers, mostly children, and by inducing current smokers to refrain from quitting.[2]

A substantial majority of published studies on the effects of tobacco advertising have concluded that there is a causal relationship between increased advertising and increased consumption of cigarettes.[2] In a comprehensive study of cigarette advertising and consumption in 33 different countries, the New Zealand Toxic Substances Board concluded:

- Strict government controls on tobacco advertising are accompanied by marked reduction in smoking rates; in the absence of such controls, smoking increases.
- Total advertising bans are accompanied by falling tobacco use rates four times greater than partial bans.
- Where tobacco advertising has been outlawed or severely restricted, the percentage of young people who smoke has decreased more rapidly than in countries where it has been less restricted.
- In countries where tobacco has been promoted virtually unrestricted, consumption has increased dramatically.

The report concluded that "advertising is directly related to the number of cigarettes smoked; increased advertising means more cigarettes smoked, and less advertising means fewer smoked."[6]

Hooking our children

Tobacco company advertising influences children and teenagers in the same three ways it can influence adults: it can encourage them to start smoking; influence the brand they choose to smoke; and discourage them from quitting.

There is ample evidence that cigarette advertising and promotion do influence brand decisions among underage smokers. Children and teenagers smoke the three most heavily-advertised brands—Marlboro, Camel, and Newport—at a rate far in excess of the overall market: 86% of underage smokers versus 35% overall.[7] The Joe Camel campaign caused nearly one million underage smokers to switch to the Camel brand, taking that brand's share of the illegal underage market from almost nothing to approximately one-third.[8]

Several new studies provide solid evidence that, beyond influencing which brand underage smokers use, tobacco advertising actually increases the total number of youngsters smoking. Increases in teen smoking initiation rates occurred following mass advertising campaigns in 1912, in the 1920s, and in the late 1960s. The first national cigarette advertising campaign began in 1912 for Camel cigarettes; between 1910 and 1920, there was a 66.2% increase in male teenage smoking initiation rates. The first Lucky Strike and Chesterfield cigarette advertisements targeting females during the 1920s resulted in an increase in smoking rates among teenage girls. There was another abrupt increase in smoking initiation rates among girls younger than 18 when Virginia Slims and other so-called feminine cigarettes began to be marketed around 1967.[9] In the six years immediately following Philip Morris' introduction of Virginia Slims cigarettes, with the theme of associating smoking with independence, physical beauty, and weight loss, the number of teenage girls smoking more than doubled. During the same time, the number of teenage boys smoking actually declined slightly.[2]

Cummings and coworkers[10] demonstrated that from 1980 to 1989, teenage smoking initiation rates correlated with total advertising and promotional expenditures. National teenage smoking initiation rates reached the highest level of the decade in 1988, the year the Joe Camel cartoon advertising campaign was launched.[10] Pierce and colleagues documented that a 4-year decline in smoking among 16- to 18-

year-old Californians was halted and replaced with an abrupt increase in 1988, after the introduction of the Joe Camel campaign.[11] These increases in adolescent smoking rates also have been documented in the most recent national surveys of 8th, 10th, and 12th grade students.[12]

Joe Camel and friends

RJR Nabisco's Joe Camel advertising campaign is a good example of how a tobacco company hit upon an effective method to influence children. An analysis of the evolution of advertising for RJ Reynolds' cigarette brands during the 1980s showed the company struggled to break Marlboro's stranglehold on the youth market. For each brand analyzed, the advertising themes and imagery were obviously reaching for a younger audience with each new generation of ads. Many of Reynolds' ads violated even the tobacco industry's own code of advertising ethics, as it tried to influence young people with images of athletic excellence, risk-taking, and glamorous lifestyles.[13]

Nothing, however, worked, until 1988, when RJR Nabisco came upon the one advertising technique almost guaranteed to appeal to youth: a cartoon character. The Joe Camel campaign has not had much effect on Camel's overall market share, but has dramatically boosted the brand's share of the underage market from virtually nothing to one third of the total.[14]

Additional evidence comes from the United Kingdom, where a Joe Camel clone has produced an unequivocal increase in teenage smoking. Like the Joe Camel campaign, the "Reg" campaign for Regal cigarettes is based on a fictional cartoon character who shows disrespect for convention while spouting adolescent humor. English authorities were able to demonstrate that teenage smoking increased significantly only in those regions of the country where the Reg campaign had run.[15]

Another example is provided by the marketing campaign of U.S. Tobacco, which has developed what it calls a "graduation strategy" to attract youthful beginners to sweetened brands of spit tobacco with pediatric doses of nicotine (e.g., Skoal Bandits), often accompanied by instructions on how to use them. As they develop tolerance to the physiologic effects of nicotine, the company "graduates" them to brands that deliver higher concentrations of the drug (e.g., Copenhagen). Advertising expenditures for starter products are far out of proportion to their overall market share, documenting how important the company perceives the role of advertising to be in attracting new users. The company's basic starter product, Skoal Bandits, commands 47% of the company's advertising budget, even though it has only a 2% overall market share. Its highest nicotine product, Copenhagen, on the other hand, commands only 1% of the advertising budget, while it has a 50% market share.[16] Copenhagen users are already safely addicted; new starters must be lured into the addiction with advertising and free samples. The result of the campaign has been an epidemic of spit tobacco use among children.

Television advertising and beyond

Until the end of 1970, television was a highly effective medium for cigarette makers to influence children to smoke. In 1962, for example, 4 of the 10 favorite television shows of children aged 6 to 11 featured cigarette advertising.[17] That year, the president of the National Association of Broadcasters urged restraints against "the use of commercials especially designed to influence the very young and beginning smoker."[18] RJ Reynolds even sponsored the Flintstones cartoon show and commissioned ads in which Fred Flintstone and Barney Rubble slipped off behind the house to smoke when they were supposed to be doing housework, the perfect enticement to a rebellious adolescent (showing that the company knew how to reach kids with cartoons long before Joe Camel came along). By the late 1960s, the average teenager saw 60 television ads for cigarettes each month. Cigarette smoking among teens increased by about 40% during the early 1960s.[19]

Since cigarette advertising was outlawed from television in 1970, cigarette companies have had to become more creative—and spend more money—to recruit youthful replacement smokers. Cigarette promotional expenditures have increased at a rate nearly triple the rate of inflation. **Figure 1** shows the increase in advertising and other marketing activities being used by tobacco companies to offset social trends that are pushing down tobacco consumption rates. Note, for example, the 27% increase in expenditures during 1988, the year the Joe Camel campaign made its debut.

Tobacco marketing takes many forms other than advertising, including the giving away of promotional items ranging from relatively small items such as cigarette lighters and baseball caps to expensive items available through coupon redemption. The very nature of some of these products suggests that they are intended for a young audience. Slade[20] has shown that a substantial proportion of underage minors have acquired tobacco company promotional items. At least one advertisement that included a coupon for free Camel cigarettes appeared to be directly targeted at minors, since it

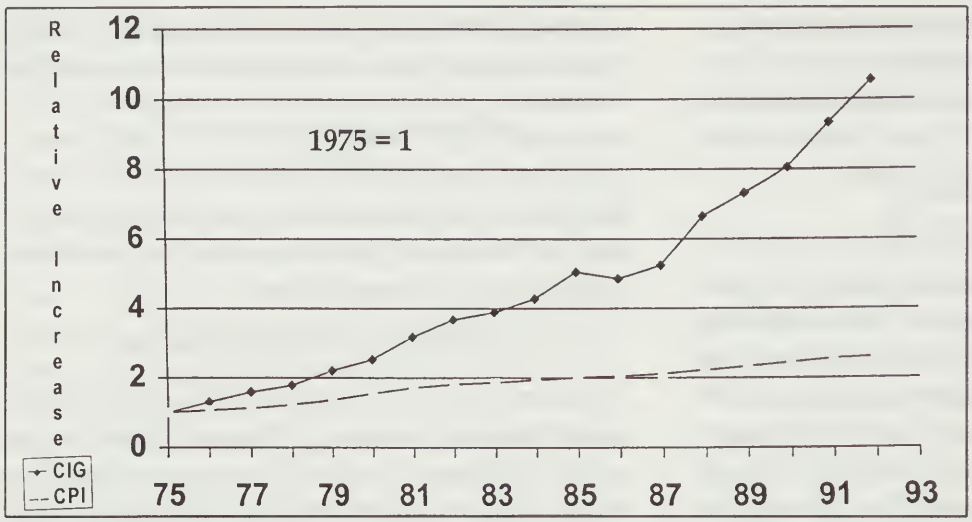


Figure 1. Relative increase in cigarette advertising and promotion expenditures compared with changes in the value of the dollar as measured by the Consumer Price Index (CPI), 1975-1992

included the instructions to have a stranger redeem the coupon.[21]

Tobacco companies select advertising media that also betray that the real audience is youth. During the 1980s, there was a steady migration of cigarette advertising into more youth-oriented publications.[22] One study reviewed 30 national magazines to ascertain the quantity of cigarette advertising in each.[23] Magazines with sexually-oriented themes and those concerning entertainment had the highest tobacco ad content. For many of these publications, such as *Sports Illustrated*, *Playboy*, and *Penthouse*, teenagers constitute a quarter or more of all readers. News and business magazines had far fewer cigarette ads. Furthermore, the ads in youth-oriented magazines tended to be more expensive, multipage or pop-up ads.

The tobacco industry code of advertising ethics prohibits direct advertising in college publications. (Tobacco companies, however, are taking credit for something that was forced upon them; by the time they "voluntarily" stopped pushing cigarettes in college newspapers, most papers had already dropped them). Nevertheless, the code does not stop tobacco companies from reaching college students in magazines like *Cosmopolitan*, which its editors claim is the leading publication on college campuses. During the month of the study,[23] *Playboy, Penthouse, Cosmopolitan*, and *Rolling Stone* were found to contain 57 pages of cigarette advertising, and the reader could collect coupons worth a total of 13 packs of free cigarettes. By contrast, there were no cigarette ads (or offers for free packs) in *Business Week, Fortune, or Forbes.*

Their protestations notwithstanding, there is reason to believe that tobacco industry executives are clearly aware of the economic imperative of recruiting children to use their products, and that they deliberately craft marketing strategies accordingly. Documentary evidence has revealed that both RJR Nabisco[24] and Philip Morris[25] have conducted research into adolescent smoking behavior. On at least two occasions, RJR Nabisco managers have sent memos instructing their staff to intensify cigarette promotions in the vicinities of high schools.[3]

A recent *Advertising Age*/ Gallup poll showed that 68% of Americans believe that "cigarette ads influence children and teenagers to smoke," and that 66% believe that some cigarette ads are "specially designed to appeal to young people."[26] A poll commissioned by The Robert Wood Johnson Foundation found that 73% of adults think that limiting tobacco companies to using only tombstone advertising—which would forbid all use of pictures and colors—would make smoking less appealing to youth.[27]

The 4-A model of cigarette advertising

As an alternative to the tobacco industry's BS theory of cigarette advertising, Stop Teenage Addiction to Tobacco (STAT) has developed the 4-A model shown in **Figure 2**. If cigarette advertising and promotion do have a more powerful impact on young people than on older smokers, the 4-A model would help explain why teenage smoking rates have remained stubbornly high while adult smoking rates have declined significantly.

According to the 4-A model, advertising provokes the initial demand for tobacco products by associating their use with the healthy, glamorous, and athletic lifestyles to which young people aspire (A-1). Then, easy access to tobacco products provides a ready source of supply. It has been documented that a majority of retail tobacco outlets around the country will sell tobacco to minors in violation of the law, and on multiple occasions, tobacco company representatives have been videotaped giving free tobacco samples to minors (A-2).[28]

Soon after the first use, the addictive process begins (A-3). Here, it is instructive to quote from a 1977 research document obtained in Canada from Imperial Tobacco Ltd.:

> However intriguing smoking was at 11, 12, or 13, by the age of 16 or 17 many [young smokers] regret their use of cigarettes for health reasons and because they feel unable to stop smoking when they want to. Over half claim they want to quit. However, they cannot do so any easier than adults can.[29]

Finally, as the addicted smoker (or chewer) increasingly regrets having ever started, advertising is used to reinforce the addiction by continuing the mental association between smoking and attractive lifestyles, and by downplaying the potential risks (A-4). The following case study illustrates the 4-A model.

Marlboro cigarettes were transformed during the mid-1950s. Originally created as a cigarette for women (at one point even featuring a red filter to hide lipstick stains), Marlboro was "repositioned" for the male market through the use of advertising featuring cowboys. The advertising created an association in young minds between Marlboro cigarettes and the freedom and independence of the open range (A-1). Philip Morris hired college students, paying them $50 per month to give free cigarettes to nonsmoking freshmen (A-2). It was not long before those students were addicted customers (A-3). As W.L. Dunn, a senior executive for Philip Morris, stated in a letter produced for a 1972 Council for Tobacco Research conference:

> Think of the cigarette pack as a storage container for a day's supply of nicotine. Think of the cigarette as a dispenser for a dose unit of nicotine. Think of a puff of smoke as the vehicle for nicotine.

Recent press reports on the internal research activities of Philip Morris scientists confirm that the company mounted a well-funded, ongoing addiction research enterprise.[25]

As Marlboro smokers grew older and began to worry about their health, Philip Morris (in collaboration with other tobacco companies, the Tobacco Institute, the Council for Tobacco Research, and a host of marketing and media organizations) participated in a cynical conspiracy to keep from the public what it knew about the addictive, lethal nature of smoking, and to convince smokers that modern technology had solved the problem anyway, if they only selected the right filter. Many were influenced to either refrain from quitting or to consider switching to a so-called low tar and nicotine brand (such as Philip Morris' Merit brand) as a safe alternative to quitting (A-4).

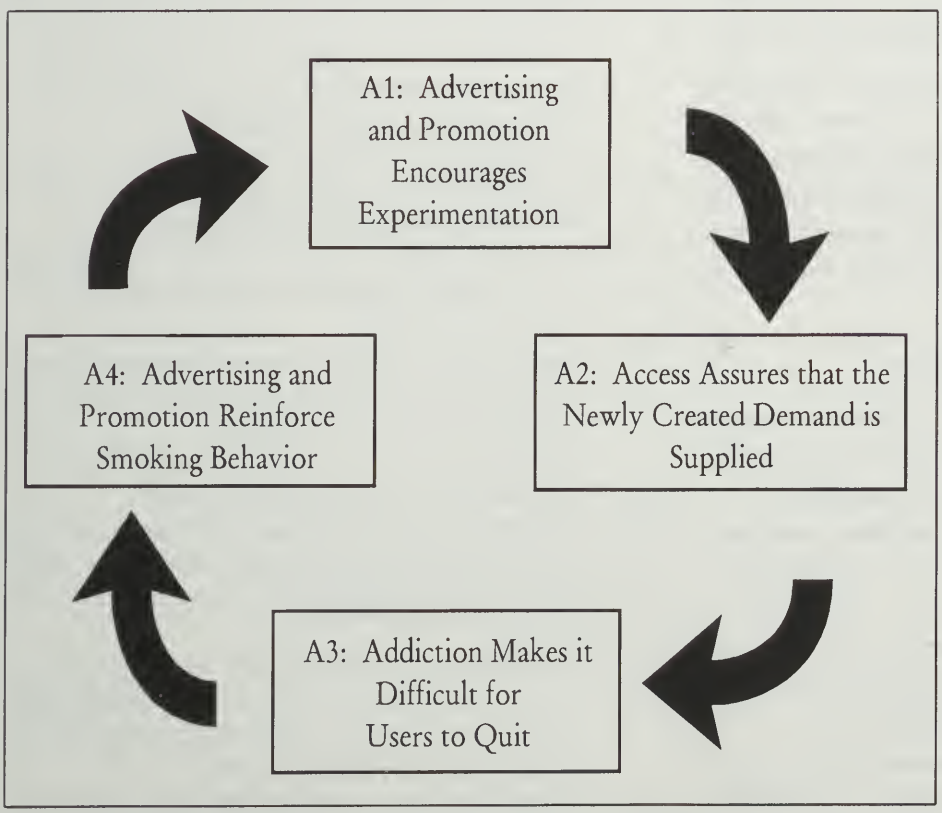


Figure 2. The 4-A model of cigarette addiction

Policy options

If tobacco were introduced today, it would never be approved for human consumption. Although it is not practical to make tobacco illegal, we should certainly prohibit any activity that has the effect of stimulating the consumption of this dangerous, addictive drug. Following is a suggested three-phase process.

Phase one: limited measures

- Outlaw tobacco sponsorship of all sporting, cultural, and other events.
- Outlaw Joe Camel and any other advertising imagery that is likely to be attractive to children.
- Encourage individual communities to outlaw tobacco billboard advertising, especially where it can be shown to unfairly target low-income and minority communities.

- Use tobacco tax money to finance massive counter-advertising campaigns.

Phase two: moderate measures

- Restrict tobacco companies to using only tombstone advertising, which would not be allowed to contain any colors or images, only black-and-white words.
- Require cigarettes to be sold only in generic packages, prohibiting brand names, logos, colors, and other insignia of an individual brand name.

Phase three: ultimate measures

- Outlaw all tobacco industry advertising and marketing activities.
- In recognition of the harm being caused by American tobacco companies in other nations, allow no domestic firm to engage in any marketing activities abroad that are not permitted in the United States.

We believe that if we are to prevent adolescent tobacco addiction, legislation must eventually be enacted to outlaw all forms of tobacco marketing. Tobacco companies have proven time and again that they can surmount any partial restrictions. When television advertising was outlawed, for example, Philip Morris and RJR Nabisco made sure that their cigarettes received plenty of television exposure by purchasing billboard space in major professional sports stadiums, sponsoring sporting events, and arranging to have their cigarettes promoted in movies—including movies made specifically for children—that would eventually be replayed on television. When other countries outlawed cigarette advertising, tobacco companies used devious means to get around those bans. For example, RJR Nabisco promoted Camel boots using exactly the same advertising theme that was used for Camel cigarettes before it was outlawed in several European countries.

What physicians can do

The policy changes mentioned above will require a major political effort. But individual physicians can do a great deal right now to help create the necessary environment:

- Do not allow any magazines in waiting rooms that have cigarette advertising, and post a sign explaining why (that it targets children).
- Instead, place pro-health materials in your waiting rooms. To request materials from the Smoke Free Maryland Coalition, call 1-800-492-1056.
- Support and participate in counteradvertising activities, such as the Emphysema Slims tennis tournaments sponsored by Doctors Ought to Care (DOC).
- Become involved in local actions to enhance enforcement of laws to prevent the sale of tobacco to minors, outlaw tobacco advertising on billboards, and prohibit giving away free cigarette samples and promotional items.

Conclusion

As long as tobacco companies are able to spend billions of dollars each year to addict children to tobacco, public health education and promotion efforts are unlikely to succeed. Tobacco addiction is the most important public health issue of our time, and every physician can play a role in helping to end the epidemic of tobacco-related disease and death by preventing the onset of this corporate-induced pediatric illness.

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LETTER TO A FRIEND

February 2, 1995

Dear Daniel,

I heard that you were thinking about smoking. Do you know what that can do to you? It could make your lungs black, and you could get cancer. Plus you would have very bad breath and could have yellow teeth. I know you'll never get a girlfriend then. We do alot of stuff together. If you start smoking, I'll still like you, but, I won't want to be around you that much. If you smoke around me, it will hurt my lungs, too.

Why do you want to smoke? Daniel, you know there is no good reason why you should start a bad habit. Bad habits are very hard to quit, maybe even impossible.

Well, buddy, thanks for listening to my feelings. Don't blow your future on a cigarette!

Your Pal,
John Perdue

Ed. Note: John Perdue is a student at Woodson Middle School in Crisfield, Maryland. His letter was presented at the 1995 Kids Day in Annapolis.

Involuntary smoking and the health of children

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Active cigarette smoking is the major preventable cause of morbidity and mortality among adults in the United States,[1] as established by extensive research largely carried out since the 1950s. These findings led to diverse initiatives to prevent young people from starting to smoke and to promote cessation of smoking. Protecting children from the effects of involuntary or passive smoking also has become a public health concern as evidence has emerged on the effects of exposure of nonsmokers to second-hand smoke. Even as early as the 1950s, there was concern that children involuntarily exposed to tobacco smoke may be adversely affected. A case report in 1950 described an infant whose asthma improved after exposure to household tobacco smoke was ended.[2] The first causal links of involuntary smoking to adverse effects in children came from research on the consequences of smoking during pregnancy.[1] Maternal smoking during pregnancy reduces birth weight and increases risk for miscarriage, premature labor and delivery, perinatal morbidity, and death.[1]

By the late 1960s, reports from observational studies were beginning to indicate that involuntary smoking also adversely affects the respiratory health of children.[3] Accumulating evidence during the 1970s linked maternal smoking to increased occurrence of lower respiratory illnesses, such as bronchitis and pneumonia, during the first year of life.[4] Studies of schoolchildren, largely reported during the 1970s and 1980s, showed that parental smoking increases the frequency of respiratory symptoms and reduces the growth of the lung during childhood.[5]

By 1986, the evidence was sufficiently compelling to support reviewing panels' conclusions on the adverse consequences of involuntary smoking. The 1986 report of the Surgeon General on smoking and health[4] and a 1986 report by a panel of the U.S. National Research Council[6] comprehensively reviewed the data on involuntary exposure to tobacco

smoke and reached comparable conclusions. Both reports concluded that exposure to environmental tobacco smoke (ETS) causes respiratory disease, including lung cancer, in nonsmokers. For children, both reports also similarly concluded that maternal smoking is associated with increased respiratory illnesses in early childhood, increased frequency of respiratory symptoms, and reduced lung growth.

In 1992, the U.S. Environmental Protection Agency (EPA) published its assessment of the respiratory effects of involuntary smoking,[7] reaching conclusions similar to those of the earlier reports. The classification of ETS as a Class A carcinogen has potential regulatory implications and has been widely publicized. Although attention has focused on the assessment of carcinogenicity, the report also addressed the effects of involuntary smoking on children and extended the findings of the earlier reports, based on the more recent literature. For children, the report found that cigarette smoking by parents was a significant source of morbidity.

This article is a selective review of a large body of scientific evidence regarding the effects of involuntary exposure to tobacco smoke on the health of children (more comprehensive reviews[4,5,7] are available). Policy implications of the evidence also are presented.

Involuntary exposure to environmental tobacco smoke

Overview and definitions. Nonsmokers inhale a mixture of sidestream smoke released from the cigarette's burning end and mainstream smoke exhaled by the smoker. The mixture is now widely referred to as environmental tobacco smoke or ETS. The term *second-hand smoke* also has been used to refer to the mixture. Inhalation of ETS is referred to as passive or involuntary smoking. ETS is an inherently dynamic mixture that changes with dilution and aging of the smoke.

Concentrations. Tobacco smoke is a complex mixture of gases and particles that contains thousands of individual compounds.[1] The smoking of tobacco indoors increases levels of many substances including respirable particles, nicotine, polycyclic aromatic hydrocarbons, carbon monoxide, acrolein, and nitrogen dioxide. The impact of smoking on indoor air quality depends on the number of smokers, the intensity of smoking, the size of the indoor space, the rate of exchange between indoor and outdoor air, and the use of air cleaning devices. Because ETS is a complex mixture, there is no single component that can be measured as an index of potential toxicity for all adverse health effects. Nicotine is a highly specific marker; there are no sources of airborne nicotine in indoor air other than tobacco smoke. Some other components of ETS that can be measured in indoor air are less specific, as they have multiple sources; for example, respirable particles, i.e., particles in the small size range that penetrate into the lung, enter homes from outdoors and are also created by routine human activities as well as by other combustion sources.

Several components of cigarette smoke, including particles and gas-phase compounds, have been measured in indoor air to describe patterns of exposure. For the home environment, where children receive the bulk of their exposure to ETS, nicotine and respirable particle concentrations have been measured most often. For example, the contribution of smoking in the home and other places to personal exposure to respirable particles has been assessed by placing samplers directly on subjects and also in their homes. These studies have shown that cigarette smoking can be a dominant source of exposure to these particles.[5] In a study involving homes in six U.S. cities, it was found that the presence of a pack-a-day smoker almost doubled the usual indoor level of particles.[8] Nicotine levels in homes have also been monitored. These studies indicate the overwhelming contribution of exposures at home to the total exposures to ETS received by children.[5] Indoor monitoring for 20 volatile organic compounds in homes in several communities showed increased concentrations of benzene, xylenes, ethylbenzene, and styrene in homes with smokers compared to homes without smokers.[9]

Biological markers of exposure. Biological markers of exposure are substances that can be measured in body tissues or fluids. The demonstration of ETS components or metabolites in body fluids strengthens the biological plausibility of links between ETS exposure and adverse effects. Biological markers assessed in children include cotinine, a metabolite of nicotine, and adducts of polycyclic aromatic hydrocarbons with albumin.[10] Cotinine levels measured in children have shown that smoking by parents is the predominant determinant of the level of children's exposure to ETS.[11] The demonstration of adducts with polycyclic aromatic hydrocarbons documents that exposure to carcinogens in ETS begins in childhood.

Prevalence of childhood exposure. Although smoking patterns have shifted rapidly during recent decades, gains in reduced smoking have been least among young women, particularly those with less education.[1] In 1991, 22% of women aged 18 to 24 were smokers; for women aged 25 to

44, the prevalence was 28%. Slightly higher percentages of men of similar ages also smoked. A substantial percentage of children are likely to have smoking parents. Data from a 1988 national survey show that about 50% of U.S. children less than five years of age are exposed to ETS.[12] The prevalence of exposure increases with declining household income and level of maternal education.

Adverse effects of ETS on children

Lower respiratory tract illnesses. Extensive epidemiologic evidence from throughout the developed world links ETS exposure, particularly from maternal smoking, to increased risk of more severe lower respiratory tract illnesses, such as bronchitis, bronchiolitis, and pneumonia.[13] Although most studies have focused on maternal smoking, studies in areas of China where women do not smoke show that paternal smoking alone can increase the incidence of lower respiratory illness.[14] The risk increases with the level of exposure[13] and is manifest primarily during the first year of life. ETS exposure is presumed to increase risk for infection by respiratory pathogens, primarily respiratory viruses, rather than to have a direct toxic effect. The consistent finding in developed countries that smoking in the household increases risk for lower respiratory illnesses has not been replicated in studies in less developed countries, perhaps reflecting differences in patterns of smoking and of the infecting organisms. For school-age children, parental smoking also increases the occurrence of respiratory illness episodes.[14]

In the EPA's risk assessment, children less than 18 months of age were estimated to suffer 150 000 to 300 000 new cases of lower respiratory illness annually because of ETS exposure. The risk assessment attributed 7500 to 15 000 hospitalizations annually to ETS.

Respiratory symptoms. Data from many surveys show a greater frequency of the most common respiratory symptoms (cough, phlegm production, and wheeze) in the children of smokers.[14]

Asthma. One of the most common chronic diseases of childhood, asthma is characterized by increased responsiveness of the lungs to inhaled pollutants, such as ETS. Exposure to ETS could plausibly contribute to the onset of asthma or exacerbate the status of children who have the disease. Inflammation of the airways is a hallmark of asthma and inhalation and deposition of ETS could sustain or increase the degree of inflammation. ETS could also have an impact on the occurrence of asthma and the clinical status of children with asthma by increasing the frequency of lower respiratory tract illnesses.

There is emerging evidence that involuntary exposure to tobacco smoke may affect airways responsiveness and function beginning as early as gestation. When airways responsiveness is assessed in the first weeks following birth, infants whose mothers smoked have increased airways responsiveness.[15] Other measures of airways function also show effects of maternal smoking during gestation.[16] One interpretation of these data is that maternal smoking affects airways development and thereby increases risk for wheezing illnesses. Although these studies indicate potential

Environmental Protection Agency conclusions

- Exposure to ETS is causally associated with an increased risk of lower respiratory tract infections such as bronchitis and pneumonia. In infants and young children up to 18 months of age, 150 000 to 300 000 cases annually may be attributable to ETS.
- Exposure to ETS is causally associated with an increased prevalence of fluid in the middle ear, symptoms of upper respiratory tract irritation, and a small but significant reduction in lung function.
- Exposure to ETS is causally associated with additional episodes and increased severity of symptoms in children with asthma; 200 000 to 1 000 000 asthmatic children may have their condition worsened by exposure to ETS.
- Exposure to ETS is a risk factor for new cases of asthma in children who have not previously displayed symptoms.

Source: U.S. Environmental Protection Agency, Office of Research and Development, Office of Air and Radiation. *Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders.* Washington, DC: U.S. Government Printing Office: 1993.

mechanisms by which involuntary smoking could cause asthma, the evidence to date remains sufficiently inconsistent that the EPA risk assessment concluded ETS is a risk factor for asthma but stopped short of characterizing the relationship as causal.

There is stronger evidence that involuntary smoking worsens the condition of children with asthma, thereby increasing morbidity. Asthmatic children whose parents smoke have increased numbers of emergency room visits and are more likely to use asthma medications.[17] They also have a higher degree of nonspecific airways responsiveness than children with asthma whose parents do not smoke.[18] The EPA risk assessment report concluded that involuntary smoking is causally associated with additional episodes of asthma and increased severity of disease in asthmatic children. The report estimated that the status of at least 200 000 and possibly as many as 1 000 000 children with asthma is adversely affected by ETS exposure.

Middle-ear disease. Both acute otitis media and persistent middle-ear effusions have been associated with involuntary smoking in a number of studies.[18] Firm conclusions have not yet been offered on this evidence by review panels.

Lung growth and development. The lung develops and completes its maturation during early childhood and continues to increase in size as the child grows. The lung may be particularly vulnerable to injury; in fact, studies of lung function and airways responsiveness shortly after birth indicate that even exposure *in utero* may have adverse effects. A number of longitudinal studies have now shown that involuntary smoking reduces the rate of lung function growth during childhood, as concluded in the 1986 report of the Surgeon General.[4] In one study, exposure of a child to a mother who smoked throughout childhood was estimated to reduce growth of one measure of lung function by about 10%.[19]

Cancer. The data on childhood cancers and passive smoking are extremely limited, although a larger literature addresses smoking during pregnancy.[18] The demonstration of increased levels of carcinogen biomarkers provides plausibility to concerns that ETS exposure in childhood could increase cancer risk, whether for childhood cancers or cancers during adulthood. Several studies have suggested links between ETS exposure in childhood and subsequent risk for cancer, including lung cancer, during adulthood.[20,21]

Sudden infant death syndrome (SIDS). The EPA risk assessment reviewed eight studies of maternal smoking and SIDS and found strong evidence for increased risk for infants whose mothers smoke. Because we lack an understanding of mechanisms leading to SIDS, the EPA did not assess the causality of the association. A recent multi-center, case-control study found elevated risks for SIDS in relation to both maternal and paternal smoking.[22]

Reducing the effect of ETS exposure on children

Passive smoking begins before birth and continues for many across the full lifetime. Although adults can choose smoke-free environments, a child who lives with smoking parents does not have this choice. Samet, Lewit, and Warner[11] recently addressed policy options for reducing the exposure of children to ETS. Restrictions on smoking in public places and schools have eliminated one source of exposure; most daycare centers have policies that prohibit employee smoking, but only a few states require daycare centers to be smoke free.[23] Virtually no legal or regulatory measures apply to smoking in the home that results in exposures of children to ETS.

Samet, Lewit, and Warner[11] considered that education of parents would have a central role in reducing exposures of children to ETS and viewed intervention by health care providers as critical. Key points suggested for intervention were during pregnancy, at birth, at well-child visits, and at visits for illnesses that may associated with ETS.[21,24] Intervention in early pregnancy would reduce the adverse effects of maternal smoking on the child and potentially increase the likelihood of successful cessation after birth. During well-child visits, health care providers should routinely assess the exposure of children to ETS and maintain counseling for parents who continue to smoke across the series of well-child visits. Parents should also learn that their smoking increases the likelihood that their children will smoke and that their children may be particularly vulnerable to active smoking because of the reduced lung growth and the increased asthma risk associated with ETS exposure. Physician visits with sick children, particularly for those with respiratory ailments associated with smoking, may provide a particularly opportune time for education. Targeted diagnoses should include asthma, lower respiratory illnesses, and chronic otitis; health care providers should be certain to assess ETS exposures of children with any of these diagnoses. Intervention to reduce exposure may prove cost-effective as the burden of ETS-related morbidity is lowered. Of course, any educational interventions need to be appropriate for the groups of concern.

There are few avenues for intervention outside of educating parents. In the United States, warning labels have not

addressed involuntary smoking and children, although child-related health warnings have been placed on packages in other countries.[11] One of the U.S. messages does warn against adverse effects on the fetus: "Smoking by pregnant women may result in fetal injury, premature birth, and low birth weight." For the future, the challenge will lie in finding effective ways to educate parents about the adverse effects of their smoking on their children, without being coercive or violating the privacy of the home.

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"If you keep smoking until you are 21, your clothes will stink, your walls will be yellow, and your breath will smell awful."

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Woodson Middle School
Crisfield, Maryland

Smoking cessation counseling in adults and children: the clinician's role

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ABSTRACT: *Clinicians can profoundly improve the nation's health by implementing recently developed smoking cessation counseling strategies. Although not specifically validated for children and adolescents, young people are likely to benefit from many of the methods used successfully with adults. In the "minimal contact" setting of an office visit, clinicians can achieve substantial long-term quit rates by identifying all smokers through the medical chart, enlisting the help of ancillary personnel, focusing on patients who are ready to quit, and arranging follow-up. Physicians are more likely to be effective if they recognize that smoking cessation is a long-term process that may require multiple quit attempts for success. This article reviews office-based approaches to smoking cessation counseling, tobacco use prevention in children and adolescents, and pharmacologic treatment of nicotine addiction.*

One of the greatest unmet opportunities in public health is the chance to increase smoking cessation rates. Physicians have a unique opportunity to improve the lives of their patients profoundly and on a massive scale. "Tobacco addiction is the single chief avoidable cause of death in our society and the greatest public health issue of our time" (C. Everett Koop, M.D.).

Although successful smoking cessation methods have been developed for adults, there has been little systematic study of these methods in children and adolescents. Following is a general discussion of office-based smoking cessation that pertains primarily to adults and a summary of approaches to cessation and prevention for children and adolescents.

Despite making some progress in encouraging their patients to quit smoking, physicians as a group have much room for improvement. If only half of U.S. primary care physicians helped their patients achieve quit rates of only 10%, the result would be a doubling of national quit rates, with 3 million additional ex-smokers every year.[1] Specialist physicians are no less obligated to provide cessation counseling. For all physicians, cessation counseling may provide the greatest opportunity to affect their patients' health. About one half of all smokers eventually die as a result of smoking itself.[2,3] Smokers overall die eight years prematurely, and those who die from smoking lose an average of 15 years of life. Many die 25 or more years prematurely.[4] Only about half of all smokers, however, report that their physician advised them to quit.[5] Yet more than 70% of smokers see a doctor yearly, and most see a physician an average of 3 to 4 times per year.

Barriers and solutions

Frustration with relapse. Perhaps the greatest barrier faced by physicians is frustration with the apparently low success rate for a given patient on a given quit attempt. It must be recognized that relapses are an integral, expected part of the smoking cessation process; multiple quit attempts are usually required for long-term success. Viewing the process in this way prevents frustration and increases enthusiasm and satisfaction on the part of physicians. This attitude is also important for patients. Physicians should help them interpret a relapse not as a failure, but as a step forward in the smoking cessation process. Qualitatively different from weight reduction counseling, smoking cessation counseling has achieved the status of a science with validated techniques resulting in predictable long-term success rates.

Lack of time. Effective "minimal contact" counseling can be performed in less than three minutes. Smoking cessation counseling is many times more cost- effective than treating hypertension or hyperlipidemia, for example.[6] The office can be set up to use ancillary staff such as secretaries. If a physician's goal is to improve patients' health in the most effective way possible, management of nicotine addiction must be a priority.

Tailoring the message to the smoker's stage of readiness is a time saver. It is not the level of addiction, but the level of readiness to quit smoking which most accurately predicts who is likely to quit. It is more efficient to limit detailed counseling to those who are ready for it. For those not yet ready to quit, hearing a simple, unequivocal statement that they must stop smoking, while being handed a pamphlet by the physician, has been shown to advance many to the next level of readiness, although it may not be evident at the time of the visit.

Lack of confidence. Many physicians feel unprepared and unsuccessful in treating nicotine addiction. The National Cancer Institute (NCI) and the American Medical Association publish guidelines for physicians to help their patients stop smoking.[7,8] The guides are based on a series of trials conducted in the late 1980s in busy doctors' practices to identify the practical techniques effective in a "minimal contact" setting. A few simple procedures appeared to improve quit rates substantially, including maximizing the number of patient contacts, the types of contact, and the number of people making the contact. Follow-up telephone calls and office visits were also important. The establishment of a few office procedures that involve ancillary staff will save time and improve effectiveness.

Four A's: Ask, Advise, Assist, Arrange

The NCI organized its recommendations around four *A*'s: ask, advise, assist, and arrange.

Ask. Smoking status should be "the new vital sign," as fundamental as taking blood pressure. Patient charts should be marked with a sticker, a smoking flow sheet, or in some other way to reveal smoking status at a glance. The trials conducted in physicians' offices found that only when physicians were routinely reminded to intervene (e.g., by the use of chart devices) did smoking rates significantly decrease. One study showed that the simple inclusion of a blank space for smoking status along with blood pressure and pulse on medical clinic stationery increased from 49% to 70% the proportion of smokers who received cessation advise.[9] Former smokers should be queried periodically since they may relapse even years later. As discussed below, adolescents should be asked annually about their use of cigarettes, smokeless tobacco, and other drugs.

Advise. At every encounter, regardless of the patient's chief complaint, a smoker should hear a direct, unequivocal message such as, "As your physician, I must advise you to stop smoking now." Just cutting down, of course, is not an acceptable alternative, although patients should be praised for cutting down as a step toward quitting. The messages can be brief, but they must be regular and routine.

Both the smoking and nonsmoking public remain largely unaware of the magnitude of the health risk associated with smoking, often judging taking vitamins and drinking pure water to be more important than quitting smoking. Smokers should be informed, in a respectful manner, of the extent to which smoking threatens their health. The message should be tailored to the individual smoker's concerns. For example, men have a powerful reason to quit when they learn of the acute and chronic role of tobacco as a major cause of impotence. A middle-aged woman may respond most to the nearly five-fold increase in the risk of facial wrinkling for

Figure 1. Good reasons to stop smoking

For teenagers
- bad breath
- stained teeth
- cost
- lack of independence; controlled by cigarettes
- sore throats
- cough
- dyspnea (might affect sports)
- frequent respiratory infections

For pregnant women
- increased rate of spontaneous abortion
- increased risk of low birth weight

For parents
- increased coughing and respiratory infections among children of smokers
- poor role model for child

For new smokers
- easier to stop now

For long-term smokers
- decreased risk of heart disease and cancer

For patients with family history of heart disease, cancer, etc.
- risk of death increased even more by smoking

For asymptomatic adults
- twice the risk of heart disease
- six times the risk of emphysema
- ten times the risk of lung cancer
- 5 to 8 years shorter lifespan
- cost of cigarettes
- cost of sick time
- bad breath
- less convenient and socially unacceptable
- wrinkles

For symptomatic adults, correlate symptoms with
- upper respiratory infections, cough
- sore throats
- dyspnea
- ulcers
- angina
- claudication
- osteoporosis
- esophagitis
- gum disease

For any smoker
- money saved by stopping
- feel better
- improved ability to exercise
- may live long enough to enjoy retirement, grandchildren, etc.
- may be able to work more, with less illness

Source: Glynn TJ, Manley MW. *How To Help Your Patients Stop Smoking: A National Cancer Institute Manual for Physicians*. Washington, DC: U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health; 1990. NIH Publication No. 92-3064.

heavy smokers (>50 pack-years).[10] An upper respiratory infection or other smoking-related symptom can be used as a "teachable moment." Methods and messages for adolescents and parents are discussed below and in **Figure 1**.

Assist. A small calendar in the examination room is as indispensable as a blood pressure cuff. According to the NCI monograph, smokers should be asked something like, "Are you interested in stopping smoking?" If the answer is yes, the calendar can be used to establish a quit date within the next month (no more than 4 to 6 weeks hence). This is possibly the most important step in the process. For patients who indicate they are not ready, the physician should simply advise them clearly that they should quit and personally hand them some literature. A somewhat more directive way would be to show smokers the calendar while saying something such as, "The best way to stop smoking is to select a quit date sometime within the next month." Those not ready to select a quit date will so state.

Those who select a quit date should be asked to change a few of their routines to get ready for the quit date. They may agree to avoid buying by the carton and to avoid their regular brand. It may be helpful for them to wait an additional half hour or so before their first smoke each morning. If desired, they may switch brands every pack. Whatever is agreed to should be written on a prescription pad, signed by both patient and physician, and given to the patient. The patient should see the physician making a note of the agreement for behavior change, along with the plan for follow-up. Physicians can save time by keeping in the examination room a prescription-sized, two-layer "carbonless carbon" form with an adhesive strip on the back; one copy is then attached to the patient's chart. (Custom forms may be ordered through some printing/office supply companies.) On the quit date, the smoker could mark the day by removing ashtrays, having the rugs cleaned, or going to the hairdresser or dentist.

Prior quit attempts and the reason for relapse should be reviewed. Patients should

be congratulated for quitting, even for a day. The physician should explain that smoking cessation is a process that usually requires a number of repeated quit attempts. Those who quit and relapse are much more likely to quit than those who have not tried. Patients should be helped to interpret previous attempts not as a failure, but as a learning experience, a step toward their ultimate goal. If they relapsed around smoking friends, they may need to avoid associating with smokers temporarily. If they did not use coping strategies (planned activities to cope with cravings such as chewing sugarless gum, carrying around straws, etc.), then they should try these now. If they relapsed with their morning coffee, they should switch to tea. If a party or some other smoking-associated stimulus precipitated their relapse, then these associations can be recognized and controlled or temporarily avoided. A positive, respectful approach helps to defuse one of the most common barriers for many smokers: the fear that they will not succeed. Reinforce the message that in spite of the great difficulty, they *can* quit.

The strongest predictor of relapse once the quitting process has begun is smoking even a single cigarette after the quit date. Those who smoked any cigarettes within the first two weeks had quit rates of only 5% at 6 months, compared to 50% for those with complete abstinence during the first 2 weeks.[11] This is the reason for concentrating counseling efforts in the early period. It may also be helpful to forewarn smokers that they will certainly wonder whether just one cigarette could harm them, and remind them that it should be strictly avoided.

All smokers should receive written material handed to them directly by the physician—a simple step which itself improves quit rates. Keeping written patient information handy in the examination room is a must. Pointing out the highlights or asking patients to fill in certain sections to review for the next visit will demonstrate that the material is taken seriously.

For patients who are highly addicted, the physician should consider nicotine replacement therapy. When used in combination with health professional counseling, this therapy has proven useful for the more addicted smoker. Information on assessing addiction level and the use of nicotine replacement therapy is presented below.

Arrange. Arranging follow-up is a critical step that boosts quit rates dramatically. Even just the promise of follow-up has been shown to be effective. There should be at least 2 follow-up visits; the first should be within 1 to 2 weeks after the quit date, and the second within 1 to 2 months. Among smokers who quit for 24 hours, one quarter relapse within 2 days and one half within 1 week (similar to relapse patterns for heroin).[12] Tobacco addiction is likely to be more important than whatever else patients may be seeing you for, and they will appreciate and welcome your concern. Ancillary staff can be trained to deliver much of the brief follow-up, although the physician should remain visible and interested throughout the process. Office staff involvement saves physician time and boosts success as well. Receiving counseling from multiple caregivers at multiple times improves quit rates.[13] For example, an office policy could establish that when "QD: June 25th" is written on the quick claim or routing slip, staff will transcribe this quit date into the appointment book. A notation could also be entered for the week before the quit date to generate a reminder call or note to the patient. On the quit date (or the day after), staff will be reminded to make another brief call to encourage the smoker. Offering follow-up can also provide effective public relations; patients will be impressed by your concern.

Physicians can achieve respectable long-term quit rates of 10% to 15% per year among all smokers in their practice, not just those making a quit attempt.[1] With repeated attempts, most smokers eventually do quit. In one study in a doctor's office setting, those who agreed to stop smoking and returned for several follow-up visits had long-term quit rates of almost 30% for a single quit attempt.[14] It is unfortunate that although 70% to 90% of smokers want to quit, only 30% try in any given year. Part of the unmet role of physicians is to increase the proportion of smokers who try—and try again—to quit.

A valuable resource for adults, smoking cessation groups may be helpful for smokers with few nonsmoking peers and those with a number of "unsuccessful" quit attempts. Groups usually depend on the patient's personal physician to prescribe nicotine replacement, if indicated. The typical quit rate for groups is 15% to 25% per attempt; some have documented quit rates of up to 40% per attempt.[15] Although the effectiveness of hypnosis has not been well studied as an isolated intervention, groups that use hypnosis seem to be as effective as others.

Smoking cessation and prevention for children and adolescents

Dr. David Kessler of the U.S. Food and Drug Administration has characterized nicotine addiction as a "pediatric disease." Of all new tobacco customers, 70% become addicted under the age of 18; 90% by the age of 21. Although prevention methods are increasingly well studied, there are few data showing smoking cessation groups to be effective in adolescents.[16] Thus, physicians should take advantage of the opportunity to intervene with children and adolescents who smoke or may be at risk to become smokers. Most twelfth-grade smokers are interested in quitting, and most have already tried to quit unsuccessfully.[16] Young smokers often do not appreciate the addictiveness of cigarettes and unwittingly move from experimentation to addic-

Figure 2. Recommendations for preventing and reducing tobacco use in children and adolescents

Infants and Young Children (0-4)	Older Children (5-12)	Adolescents and Young Adults (13-20)
Anticipate the child's exposure to tobacco smoke. Passive exposure causes respiratory illness, chronic middle ear effusion, and increased hospitalization. During pregnancy, smoking causes low birth weight and increased risk for premature births, miscarriages, and stillbirths.	**Anticipate** smoking among children. Risk factors for tobacco use include: smoking by parents, siblings, or friends; poor academic performance; and attitudes about tobacco that convey a willingness to try it or a denial of its harmful effects.	**Anticipate** smoking among teenage patients. Risk factors that may signal tobacco use include poor academic performance or dropping out of school and other risk-taking behavior such as use of alcohol. Peers are especially influential in the choice of behaviors during these years.
Ask about smoking in the child's home, daycare facility, or school.	**Ask** about tobacco use by the child, parents, siblings, friends. Ask about school progress and whether tobacco is discussed in school classes.	**Ask** about tobacco use by patients and their friends. Ask about participation in sports or other activities that are not compatible with tobacco use.
Advise smoking parents to stop. Strongly recommend smoke-free air for the child.	**Advise** children not to use tobacco. Emphasize the short-term negative effects of using tobacco, such as bad breath, yellowed fingers, and smelly clothes.	**Advise** all tobacco users to stop. Emphasize the short-term negative effects of tobacco use.
Assist smoking parents in stopping. Provide them with self-help materials. Help them select a quit date. When indicated, prescribe nicotine replacement or refer to another physician, if necessary.	**Assist** children in developing skills for refusing tobacco and compliment children who say they do not use tobacco products. Show children the misleading aspects of tobacco advertising.	**Assist** patients who smoke to quit. Provide them with self-help materials. Help them select a quit date. Compliment tobacco-free behavior. Help patients develop refusal skills. Show patients the misleading aspects of tobacco advertising.
Arrange to deliver nonsmoking messages and support to parents during each follow-up visit for their children.	**Arrange** more frequent follow-up visits for children experimenting with tobacco.	**Arrange** follow-up appointments with patients trying to stop: 1 to 2 weeks and 1 to 2 months after their quit date.

Adapted from Glynn TJ, Manley MW. How To Help Your Patients Stop Smoking: A National Cancer Institute Manual for Physicians. Washington, DC: U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health; 1990. NIH Publication No. 92-3064.

tion. In one study, 95% of daily smokers in high school predicted they would not be smoking 5 years after graduating, yet 75% were still smoking at follow-up 8 years later.[16]

Inquiring about the use of tobacco, alcohol, and other drugs should be a routine part of the periodic examination for adolescents. It is often helpful to begin with inquiries about the attitudes of the adolescent's friends and family toward these substances. The interviewer's response to the answers will influence the adolescent's willingness to provide information regarding personal use. To facilitate an accurate interview, the interviewer should convey an attitude of concern and awareness, rather than condemnation or alarm. It is critical to interview the adolescent alone and to assure confidentiality (except for issues of child abuse or threats to harm self or others).

Data on prevention programs and attitudes surveys indicate that adolescents generally do not respond to health risks, but are acutely concerned about negative social consequences of smoking, such as the foul odor, impaired athletic performance, the fact that smoking makes them look silly, and that "kissing a smoker is like licking an ashtray."[16]

Pediatricians and others who see very young children have the opportunity to counsel parents to stop smoking for the health of their children. Parents may be unaware of the role of secondhand smoke as a significant cause of children's respiratory infections (including bronchitis, pneumonia, wheezing, and the development of asthma). Parents also may respond to their status as role models and the fact that children of smokers are much more likely to become smokers themselves. Counseling should not be limited to parents of children with respiratory conditions, but is particularly urgent for parents of children with asthma.[17]

For physicians who care for children and adolescents, the NCI recommendations[7] add a fifth *A* to the four *A*'s of

helping patients stop smoking (ask, advise, assist, arrange). The fifth *A* is *anticipate*. By recognizing risk factors and providing "anticipatory guidance" (counseling for potential problems) to young patients who may be vulnerable to becoming smokers, physicians may be able to prevent tobacco use before it starts. **Figure 2** summarizes the NCI recommendations for preventing and reducing tobacco use in infants, children, and adolescents.

Nicotine replacement therapy

For adults who are highly addicted or who have experienced unsuccessful quit attempts in the past, particularly if there were physical symptoms of nicotine withdrawal, nicotine replacement can double or triple the quit rate. To determine if nicotine replacement is indicated, the degree of addiction can be estimated by the Fagerstrom Tolerance Test (**Figure 3**). For practical purposes, the test can be simplified to a single question: "How many minutes after you wake up do you have your first cigarette?" Thirty minutes or less indicates a high level of addiction. This is more accurate than the number of cigarettes smoked because of the great variability in the amount of nicotine absorbed.

Nicotine replacement therapy should always be provided with concomitant cessation counseling, and would not be appropriate as a telephone prescription for someone preparing to quit smoking. Common mistakes made by physicians when using nicotine replacement therapy are failing to provide the accompanying cessation counseling and prescribing too little for too brief a period.

Nicotine patch. Starting doses are 22 mg, 21 mg, or 15 mg. It is unnecessary to specify the brand name when writing the prescription. Refills should be provided. Various brands are supplied as 14 or 30 patches per box; the 22 mg patch comes 7 per box (so that one could prescribe a quantity of 2 to 4 weeks, with refills, regardless of the brand). Lower starting doses should be used in smokers who weigh 45 kg or less. All patches but one are worn for 24 hours and changed each morning. The Nicotrol brand (which produces similar blood levels despite the 15 mg starting dose) is removed at bedtime and applied after the morning shower, which may decrease the incidence of vivid dreams. No brand has been demonstrated to have sustained superiority over another. All manufacturers provide some form of supplementary support (e.g., toll-free telephone numbers or periodic mailings to the smoker).

The patch prescription should be filled ahead of time and started on the quit date. Patches cost about $4 each ($120 per month) and are not covered by many prescription plans, which may be a consideration in how many to prescribe. However, patients may be reminded that the patch is a good investment considering that smoking can cost more than $1000 per year. The package insert usually recommends using the full-strength patch for one to two months and a lower strength for an additional month. However, no data confirm the need to taper and some studies show identical quit rates for those who abruptly stop the full-strength patch.[18] It is faster for the physician to prescribe only one strength; if the patient subsequently feels the need to taper, it can be done later. It is important to prescribe the patch long enough, which may be as little as four to six weeks for some individuals.[19] Regular use during this period is important. In groups of smokers, eight weeks of therapy has been adequate,[20] although some individuals may benefit from more prolonged use. About 5% of former smokers become dependent on nicotine replacement long-term. Although the patch is not approved for use beyond six months, it is safer than smoking if the physician and/or the patient deem it to be the only alternative. In such situations, attempts at tapering would seem appropriate.

Skin irritation occurs in 20% of patients, but only 5% have to discontinue therapy. Moving the patch to a new site several times a day or using the 18-hour patch (Nicotrol) may help. Potential symptoms of nicotine toxicity are diaphoresis, nausea, tachycardia, headaches, and vivid dreams. To date, no clinically relevant drug interactions have been reported. However, smoking cessation with or without nicotine replacement may decrease the clearance of drugs such as theophylline and imipramine (Tofranil).[21]

Nicotine gum. Although the nicotine patch has been more effective in "minimal contact" (doctors' office) settings,[20] nicotine gum is indicated for patients who are intolerant of the patch. Nicorette (2 mg) and Nicorette DS (4 mg) each contain 96 pieces of gum per box. The latter is usually superior for more dependent smokers. With either dosage, at least 10 pieces should be chewed prophylactically throughout the day. Additional pieces (up 30 per day with 2 mg or 20 per day with 4 mg) can be used as needed.

Counseling on the proper use of the gum is essential. The manufacturer produces an excellent audiotape for patients that may complement physician or ancillary staff instructions. Patients must chew slowly, gently, and intermittently to minimize side effects from swallowing nicotine and maximize buccal absorption. As soon as a peppery taste is noted (after about 15 chews), the gum is temporarily parked between cheek and gums. One piece should last 20 to 30 minutes. Side effects such as nausea, hiccups, and throat or stomach irritation are usually the result of chewing too quickly. Beverages and chewing gum with sugar should be avoided for 15 minutes before or

Figure 3. The Fagerstrom Tolerance Test

Questions	Answers	Points
1. How soon after you wake up do you smoke your first cigarette?	Within 5 minutes	3
	6-30 minutes	2
	31-60 minutes	1
	after 60 minutes	0
2. Do you find it difficult to refrain from smoking in places where it is forbidden (e.g., church, library, cinema, etc.)?	Yes	1
	No	0
3. Which cigarette would you hate most to give up?	The first one in the a.m.	1
	All others	0
4. How many cigarettes/day do you smoke?	10 or less	0
	11-20	1
	21-30	2
	31 or more	3
5. Do you smoke more frequently during the first hours after waking than during the rest of the day?	Yes	1
	No	0
6. Do you smoke if you are so ill that you are in bed most of the day?	Yes	1
	No	0

Proposed scoring cutoffs	Level of addiction
0-2	very low
3-4	low
5	medium
6-7	high (heavy)
8-10	very high

Adapted from Fagerstrom KO, Heatherton TF, Kozlowski LT. Nicotine addiction and its assessment. *Ear Nose Throat J* 1990;69:763-768.

after using Nicorette; coffee, tea, juice, wine, or cola prevent buccal absorption by lowering the pH.[22] An unpleasant taste and minor throat irritation tend to subside over one to two days, although it may take as long as one week to get used to these effects. Relief of nicotine withdrawal symptoms requires 20 to 30 minutes, so techniques to distract oneself during the urge to smoke are necessary. After the gum is tapered or stopped, patients should keep a few pieces on hand for "emergencies."[23] Patients should be instructed not to smoke while using nicotine replacement as a prudent safety precaution and because it is likely to undermine their quit attempt. About 75% of those on full dose nicotine replacement have lower blood nicotine levels than they had during smoking.[18]

Contraindications. Nicotine causes fetal malformations in experimental animals. On the other hand, smoking during pregnancy and maternal smoking after pregnancy are known risks likely to be more hazardous than nicotine alone. The benefits of nicotine replacement must be weighed carefully against the risks; it would be prudent for pregnant women to attempt cessation without the patch, at least initially. Nicotine is passed freely in breast milk in levels somewhat lower during nicotine replacement than during smoking itself.

Nicotine gum is contraindicated in active peptic ulcer disease and temporomandibular joint disease. Nicotine replacement is generally contraindicated soon after a stroke or acute myocardial infarction and in patients with unstable angina or high-grade arrhythmias, although it has been used safely in large groups of patients with chronic heart disease.

Tobacco use prevention resources

Smoke Free Maryland: A Coalition for Tobacco Control

Smoke Free Maryland maintains a tobacco control clearinghouse at the Medical and Chirurgical Faculty of Maryland. To request patient education or other tobacco use prevention materials/resources, to obtain a list of smoking cessation groups in Maryland, or to find out about membership in the Smoke Free Maryland Coalition, call the Smoke Free Maryland Clearinghouse (800-492-1056).

Maryland G.A.S.P. (Group Against Smokers' Pollution)
Box 863, Bowie, MD 20718 (tel: 301-262-5867)

Membership: $10. Works on all aspects of tobacco control at the state and federal levels, including teenage tobacco addiction. Excellent newsletter. The only Maryland group devoted exclusively to tobacco control.

National Cancer Institute

Booklet How To Help Your Patients Stop Smoking: A National Cancer Institute Manual for Physicians *is available free. Call 1-800-4-CANCER.*

Action on Smoking and Health (ASH)
2013 H Street, NW, Washington, DC 20006 (tel: 202-659-4310)

Membership: $15. Excellent newsletter. Executive Director John Banzhaf initiated smoke-free airline flights and is responsible for getting tobacco advertisment off the airways in 1971.

S.T.A.T. (Stop Teenage Addiction To Tobacco)
511 East Columbus Avenue; Springfield, MA 01105
(tel: 413-732-7828; fax: 413-732-4219)

Membership: $25; includes a free copy of the book Kids Say Don't Smoke, *filled with children's own illustrations. Excellent newsletter.*

Advocacy Institute
1707 L Street, NW, Suite 400, Washington, DC 20036 (202-659-8475).

Membership: $50. Provides frequent, up-to-date action alerts on tobacco-related current news and legislative issues.

Doctors Ought to Care (D.O.C.)
5615 Kirby Drive, Suite 440, Houston, TX 77005 (tel: 713-798-7729;
fax: 713-798-7775)

Membership: $25. Founded by physicians, this group has many local chapters around the country. It focuses media attention by poking fun at the tobacco industry.

INFACT
256 Hanover St., Boston, MA 02113 (tel: 617-742-4583)

Provides information on the Philip Morris/Kraft/R.J.R. Nabisco boycott.

A study of more than 1000 elderly patch users (aged 65 through 74) found no serious adverse effects despite the fact that almost half smoked while using the patch.[24] In equivocal situations, a low-dose patch may be considered.

Other pharmacologic therapy

Clonidine (Catapres) can somewhat reduce the craving to smoke. There is suggestive but not definite evidence that clonidine modestly improves quit rates. It may be useful as an adjunct to nicotine replacement for patients who relapse or who are not candidates for nicotine replacement. It should be started 2 to 5 days before the quit attempt with a starting dose of 0.2 mg per day.[22] A history of depression or a depressed mood tends to lower quit rates significantly. Adjunctive use of an antidepressant begun several weeks prior to the quit attempt may have a role for selected patients.

Patients may be told that the average weight gain is 5 pounds during smoking cessation and that not everyone gains weight. If weight gain is a problem, behavioral approaches and exercise are indicated. An anorectic agent such as fenfluramine (Pondimin) may have an adjunctive role in the minority for whom potential or actual weight gain seriously interferes with cessation.[22]

Summary

Tobacco addiction has been our society's leading cause of preventable death for decades, yet physicians as a whole have not addressed the problem effectively with their patients. Cessation counseling and the achievement of significant quit rates are not currently rewarded or expected by physicians. In this managed care era, physicians are judged on quality-of-care issues such as patient satisfaction, but not necessarily on smoking cessation—possibly the most important and cost-effective aspect of quality care and one which is readily measurable.[25] Physicians are seen as an important, credible source of informa-

tion by their patients, 75% of whom report they would try to quit smoking if so advised by their doctor.[26]

Perhaps the simplest step any physician could take is to subscribe to the tobacco control newsletters listed on the preceding page under Tobacco Use Prevention Resources. The newsletters can be placed in the waiting room or the list itself can be copied and shared with patients. Physicians' daily contact with large numbers of citizens could be of great help in increasing the membership of these tobacco control groups.

In addition to their vital role in smoking cessation, Maryland physicians can play a unique and possibly even more important role in the primary prevention of tobacco addiction as members of the Smoke Free Maryland Coalition, a statewide network of concerned individuals and organizations working to reduce tobacco-related illness in our state. Physicians can join the coalition, join its speakers' bureau, write letters to the editor, contact elected officials, and testify at public hearings.

The initiation and reinforcement of tobacco addiction occurs at the political and societal level, sustained by the tobacco industry's wealth and massive advertising and promotion activity. The disease of tobacco addiction is the most important cause of preventable death and disease in our society. It causes one out of five of *all* deaths in the United States, killing more Americans every year than were killed in World War II. As physicians, let us learn the fundamentals of the new science of smoking cessation and rise to the challenge of this epidemic—the greatest public health challenge in history.

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Developing provider partnerships in the detection of oral cancer and the prevention of smokeless tobacco use

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More than 30 000 cases of oral cancer are reported each year in the United States,[1] accounting for approximately 5% of all cancers. The vast majority (96%) are carcinomas; the remainder (4%) are sarcomas.[1] The role of smokeless tobacco in the development of oral cancer has been well demonstrated. The current smokeless tobacco use rate among adolescents indicates the need for further screening for symptoms associated with smokeless tobacco use.

The 1970 National Health Interview Survey reported that smokeless tobacco use was lowest among young males (aged 17-19) and highest among men aged 50 and over. Between 1970 and 1985, however, smokeless tobacco use by youth increased nationwide. By 1985, the Current Population Survey showed that the smokeless tobacco use rate among males aged 16 to 19 was double that of men aged 50 and over.[2] The increase coincided with the introduction in 1970 of the U.S. Tobacco smokeless tobacco promotional campaign, which targeted younger users by hiring sports celebrities and music stars to promote smokeless tobacco products and by sponsoring sporting events to associate the products with athletic excellence.

The importance of early cancer identification and treatment has been accepted for years. Health care providers in Maryland should take pride in the medical systems in our state that lead the country in cancer treatment. However, we have failed to prevent, detect, and treat conditions of oral cancer. Maryland's age-adjusted oral cancer incidence rate is 27th in the United States and its age-adjusted oral cancer mortality rate is 4th in the United States.[3]

One major reason for high mortality rates may be delayed diagnosis. Many patients in high risk groups, such as the elderly and the economically disadvantaged, may be financially unable to visit a dentist. In Maryland, Medicare and Medicaid do not cover oral health care services,

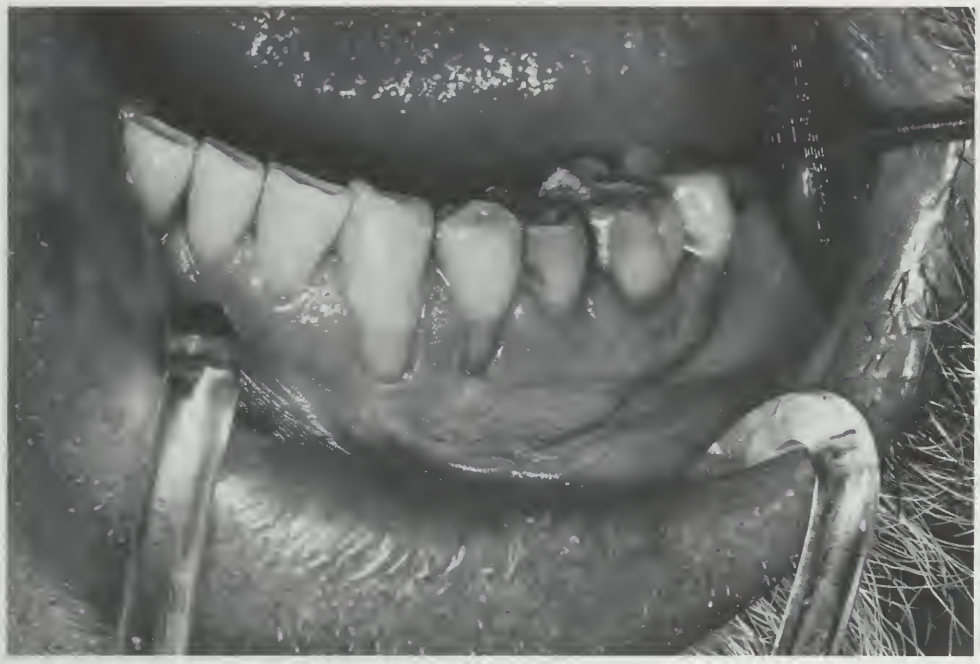


Figure 1. Advanced leukoplakia in the anterior buccal vestibule.

including emergency care, for adults. Failure to obtain preventive oral health care services, however, increases expenditures on medical treatment costs.[4] Since 38% of the American population does not visit a dentist within a one-year interval, other providers must routinely complete an oral cavity examination.[5]

During the primary health care visit, patients are sensitized to their health status and are therefore more likely to consider the provider's advice. According to a 1992 report by the U.S. Department of Health and Human Services (DHHS),[6] key informants in the study unanimously favored "strong, proactive education, intervention, counseling and advocacy roles for health professionals." A combined medical and dental approach to screening and treating users of smokeless tobacco must become standard care. Screening for symptoms from smokeless tobacco use can be a quick and inexpensive procedure performed by qualified health providers as well as dentists.

Leukoplakia

Nitroamines (carcinogens) have been detected in smokeless tobacco at levels 100 times those allowed in some foods,[7] in part because tobacco companies are not currently regulated by the Food and Drug Administration. Leukoplakia (precancerous cells) is defined by the World Health Organization as a white patch or plaque on the oral mucosa that cannot be wiped off and that cannot be classified clinically or pathologically as any other disease.[8] In one study, 46% of smokeless tobacco users had leukoplakia lesions primarily at the site where the smokeless tobacco was held.[7] Most studies show a leukoplakia rate in the range of 40% to 60% of smokeless tobacco users. The development of leukoplakia appears to be related to the frequency and duration of smokeless tobacco use and may develop as early as three to four months after use begins.[9] **Figure 1** shows mouth tissue at the site where smokeless tobacco was held.

Leukoplakia may become cancerous in 3% to 28% of patients. Because almost 50% of all smokeless tobacco users show signs of leukoplakia, it is critical that health care providers appropriately screen and evaluate patients.[9] Regardless of the diagnosis, patients should be advised to discontinue their tobacco use. If the condition has not been resolved in two weeks, a biopsy is necessary. In addition to detecting signs of oral cancer, the biopsy may give patients a powerful reason to think about quitting.

Nicotine addiction

Another consequence of smokeless tobacco use is nicotine addiction. Smokeless tobacco manufacturers have manipulated the level of nicotine in their products to recruit and retain new users and altered the pH level in the tobacco to offer various levels of nicotine absorption.[10] Brands that have slow nicotine absorption tend to be milder tasting and easier to use. Although the tobacco industry claims it is not targeting youth, cherry-flavored smokeless tobacco is currently available. Once accustomed to the effects of these starter products, young users can "graduate" to products that offer more rapid nicotine absorption (e.g., Copenhagen).

The U.S. Department of Health and Human Services reports that 37% of young users continued spit tobacco use because they were addicted.[6] In Garrett County, Maryland, where use of tobacco is prohibited on school grounds, focus group data have shown that young people are willing to swallow tobacco juice in school to maintain their nicotine level.[11] Health problems associated with that behavior include cancer of the pharynx and esophagus and stomach ulcers.

Social support

Use of smokeless tobacco products by family members has been found to contribute to smokeless tobacco use among youth. In a DHHS study, users stated that use by family members and peer pressure were the most influential reasons for trying smokeless tobacco.[6] To delay usage onset, a comprehensive strategy designed to work with the entire family is needed. Counseling by providers has been effective in encouraging patients to stop using smokeless tobacco. In the clinical setting, providers have the opportunity to discuss the negative influence of adult smokeless tobacco use on youth. Adult users who attempt to prevent their children from using tobacco often are motivated to quit to portray a positive role model.

With the assistance of resources offered by organizations such as the National Cancer Institute, American Lung Association, American Cancer Society, and American Academy of Otolaryngology-Head and Neck Surgery, providers can effectively guide their patients through the cessation process. Cessation is particularly important for adolescents, who begin to solidify behaviors at a young age. Although there is controversy regarding the use of alternate products such as mint snuff, which contains none of the harmful chemicals found in smokeless tobacco, one of the authors has found that patients who use mint snuff have been successful in their cessation efforts.

The role of the health care provider in the community

Smokeless tobacco use is a major health issue in Garrett County, Maryland. The Garrett County Health Department (GCHD) has collected data indicating that 30% of eleventh and twelfth grade males use smokeless tobacco in Garrett County.[12] Local providers have joined the GCHD in a community-wide effort to combat the use of smokeless tobacco among youth. The GCHD uses a prevention model that incorporates both individual and environmental change to reduce smokeless tobacco use in the county.

Interactive smokeless tobacco prevention classes have been provided to all Garrett County ninth grade health classes by a local dentist and a community health educator from the GCHD. The providers' first-hand experience gives them the advantage of being considered "experts" by students. Results from pre- and post-class surveys show that the tobacco prevention classes resulted in a 65% increase in students' knowledge about the dangers of smokeless tobacco use.[13]

Primary care providers interested in learning more about screening and diagnosis of tobacco-related oral health conditions may want to obtain a copy of the National Institutes of Health publication entitled *Tobacco Effects in the Mouth*.[11] It is a brief but reliable resource that includes

- a description of and illustrated guide to tobacco-induced and associated oral conditions;
- a description of the multiple, insidious effects that tobacco use has on clinical care;
- a description of a systematic method for conducting an oral examination and documenting the findings.

The recommended examination requires a limited number of instruments and should take no more than five minutes to perform. To request a copy of the publication, call the Smoke Free Maryland Clearinghouse (800-492-1056).

The Garrett County Tobacco-Free Coalition, which includes health care providers and other community leaders, works to decrease youth access to tobacco products through a merchant education program and by influencing policy and legislation. As important community opinion leaders and role models, health care providers continue to challenge the accepted norms surrounding tobacco use among youth. Concerned community residents have begun to recognize the devastating effects of tobacco use, generating further grass-roots interventions.

Recommendations

In less than ten minutes, both primary health care providers and dentists can easily conduct an oral examination to detect signs of leukoplakia and can facilitate the cessation process. Because Maryland provides little coverage for dental visits, it is even more important that primary care providers join dentists to help prevent oral cancer. As the tobacco industry is likely to continue to introduce youth to smokeless tobacco by manipulating nicotine levels, provid-

ers must also work to stimulate community-driven tobacco prevention activities.

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WHAT IS SPIT TOBACCO?

Chemicals. Keep in mind that the spit tobacco you or your friends are putting into your mouths contains many chemicals that can have a harmful effect on your health. Here are a few of the ingredients found in spit tobacco:

- *Polonium 210 (nuclear waste)*
- *N-Nitrosamines (cancer-causing)*
- *Formaldehyde (embalming fluid)*
- *Nicotine (addictive drug)*
- *Cadmium (used in car batteries)*
- *Cyanide*
- *Arsenic*
- *Benzene*
- *Lead (nerve poison)*

The above is part of an information leaflet entitled *Spit Tobacco* that is written for children and published by the American Academy of Otolaryngology-Head and Neck Surgery. In addition to offering basic information about what spit tobacco is, the leaflet discusses the physical and mental effects of spit tobacco, including leukoplakia, heart disease, gum and tooth disease, and the effects on a person's social life. It also lists early warning signs of disease and provides practical tips on how to quit.

For further information about the leaflet, contact the American Academy of Otolaryngology-Head and Neck Surgery, One Prince St., Alexandria, VA 22314; telephone 703-836-4444, fax 703-519-1587.

Preventing youth access to tobacco products in Maryland

J. Joseph Curran, Jr.

Mr. Curran is the attorney general of the State of Maryland.

In Maryland, it has been illegal for more than a century to sell or give cigarettes and other tobacco products to children. In 1886, the Maryland General Assembly enacted a law prohibiting the sale of tobacco products to children younger than 14 "to protect the health and morals of minors in the State of Maryland."[1] Today, it is illegal for retailers or manufacturers of tobacco products to sell or give tobacco products to children younger than 18.[2] The law also prohibits minors from using or possessing tobacco products.

Tobacco is one of the most deadly and addictive products to which our children will ever be exposed. Although Maryland has long recognized that children and cigarettes should not mix, efforts to improve our ability to prevent children from easily gaining access to tobacco products have been consistently blocked by the tobacco industry. It is ironic that as science and medicine are teaching us more about the health hazards related to smoking, adolescents are using tobacco products in record numbers. The statistics are startling:

- Ninety percent of all smokers begin smoking as teenagers.[3]
- Underage U.S. teens purchase more than half a billion packs of cigarettes each year.[4]
- An estimated 3.1 million U.S. teenagers are regular smokers.[4]
- Each day, 3000 more U.S. children begin smoking.[4]
- More than a million underage U.S. smokers become addicted each year.[4]
- Each year an estimated 10.4 million packs of cigarettes are sold to Maryland youth.[5]
- Each day in Maryland, 50 to 60 adolescents will smoke their first cigarette.[5]
- Maryland youth will succeed at least 90% of the time in their attempts to buy cigarettes through vending machines and when

they attempt to buy over the counter, they will succeed 2 of every 3 times.[6]

- Tobacco use results in the death of more than 7000 Marylanders each year (more than 19 deaths every day).[5]
- Tobacco use costs Maryland taxpayers more than $1 billion each year in tobacco-related medical costs, sick leave, and lost productivity.[5]

These facts dictate what our course of action must be. We must do everything in our power to help our children make the decision not to start smoking. If we do, in all likelihood we will be helping them make a lasting decision never to smoke—perhaps the single most important health decision of their lives.

Strengthening the laws

As the chief law enforcement officer of Maryland, I wanted to learn more about why children are smoking, why retailers sell tobacco products to them, and what we can do to eliminate their access to tobacco products. Together with attorneys general from other states, I participated in a study of these issues. We interviewed tobacco retailers to understand the problems they face in identifying underage buyers and refusing sales to minors, and we reviewed current literature and studies on these subjects. We developed legislative recommendations and suggestions on how businesses can prevent the sale of tobacco products to children.

The report,[7] released in December 1994, was joined by 27 state attorneys general. The study findings convinced me to take action in the 1995 Maryland General Assembly to support legislative efforts to strengthen our law.[8]

There is no doubt that the tobacco industry has been successful in marketing and selling its products to young people. There is an increasing number of teen smokers in the United States and an increasing availability of cigarettes and other tobacco products to children. Our laws are not preventing it.

I support strengthening the law in three areas: license sanctions; tobacco vending machine placement and penalties for sales to minors through vending machines; and enforcement. These efforts are also supported by the Maryland Department of Health & Mental Hygiene, which has been working on the teen smoking issue for many years.

License sanctions

To deter merchants who repeatedly sell cigarettes to minors, the Maryland district courts must have the authority to suspend or revoke a merchant's license to sell cigarettes. Without this threat, there is little incentive for a merchant to stop what can be a profitable activity. Under current law, the court may impose a fine of $300 for a first violation and up to $3000 for third and subsequent violations.[9] But a discretionary fine, without the possibility of losing a license to sell cigarettes, has little deterrent effect. The law will not have teeth until a violator's license to sell cigarettes can be revoked.

Vending machine placement and penalties for sales to minors through vending machines

Our youngest teens often purchase their cigarettes from vending machines. The state health department cites national statistics showing that children are successful 90% to 100% of the time in their attempts to purchase cigarettes through cigarette vending machines.[6] A nationwide study by the vending machine industry reported that 72% of teen smokers bought their own cigarettes.[10] To restrict children's access, it is therefore critical that the placement of cigarette vending machines be limited. Tobacco vending machines should be removed from stores, bowling alleys, skating rinks, and grocery stores. Unattended vending machines are an invitation for children to experiment with cigarettes.

In addition, district courts should have the authority to impose civil fines on merchants who sell cigarettes to minors through vending machines and on the vending machines' owners, and to suspend or revoke their cigarette business license. Merchants who have vending machines at their businesses and vending machine owners currently are exempt from the penalty provisions of the law as long as the vending machine displays a label stating the prohibitions and penalties of the sales to minors law.[11]

Enforcement

Local and state health departments and law enforcement personnel must have all the tools they need to monitor compliance with the sales to minors law. They must be able to use teenage buyers to test whether merchants are selling to underage teens. In towns and cities in other states that have done regular, unannounced compliance checking by using underage buyers, merchants' compliance with sales to minors laws has increased dramatically.[7,12] Maryland law prohibits minors from using or possessing tobacco products and has no exception for using minors as testers for law enforcement purposes.[9] Creating such an exception will increase compliance with the law and facilitate enforcement efforts. During the last legislative session, a bill that would have accomplished such changes in the sales to minors law did not

receive a favorable report from the Environmental Matters Committee of the Maryland House of Delegates. Despite testimony from business owners, children, parents, and health and law enforcement officials, the legislation was rejected by the committee and thus could not be considered by the entire House of Delegates or the Maryland Senate.

Alternatives

Cooperative efforts among law enforcement personnel, health officials, and merchants who sell cigarettes and other tobacco products is critical to stopping illegal sales to minors. Merchants must be encouraged to implement programs and strategies that prevent sales to minors.

Our study found that many merchants were receptive to our concerns about teen access to tobacco. However, they had not focused their attention on tobacco sales to the degree that they had concentrated on preventing alcohol sales to minors. All merchants should be urged to implement responsible retailing practices that will reduce sales to underage teens. Practices the report[7] recommended include:

- Effective training of employees on how to recognize underage buyers, how to check for valid age identification, and how to refuse a sale if the buyer is underage.
- Price scanning technology that can be programmed to stop for age-restricted products and require an age identification check by the cashier before the product can be sold.
- Self-monitoring using testers to shop for tobacco products and test store compliance with the law. (Under Maryland law, retailers are also prohibited from using underage buyers.)

Tobacco industry targets

We must educate ourselves and our children about the health hazards of smoking and the economic costs of tobacco-related illnesses, and we must face the reality that the tobacco industry is targeting our youth. The industry needs our children to replace the adult smokers who quit smoking or die from smoking-related illnesses.

Statistics nationwide show the tobacco industry has succeeded in luring children to smoke. During the past decade, the number of teen smokers has remained essentially constant, whereas the number of adult smokers has declined. According to the Maryland Adolescent Drug Survey, 24% of Maryland high school seniors reported monthly smoking in 1988; in 1992, 31% reported monthly smoking.[13]

At a press conference held by my office and the Department of Health & Mental Hygiene during the last legislative session, we displayed promotional items the tobacco industry uses to lure adolescents into buying cigarettes and other tobacco products: T-shirts with Joe Camel cartoon figures, miniature race cars, baseball caps, lighters, mugs, shorts, an inflatable boat—all emblazoned with the logos of the tobacco companies. Some of the items are attached to packs of cigarettes; some are redeemable with coupons found on the cigarette pack. In response to this display, one middle school student asked why tobacco companies advertise to kids when kids are not supposed to smoke. A good question.

The tobacco industry knows that to continue to make profits, it must have new smokers. The new smokers are adolescents. The tobacco industry spends more than $6 billion each year to bombard young people with the message that coolness, sophistication, and peer acceptance come with smoking.[14] Kids see this message on billboards, at the movies, on television, at tobacco-sponsored sports and music events, and through promotional campaigns. The results cited in our report attest to the success of these advertising campaigns despite laws in every state prohibiting the sale of tobacco products to children younger than 18.

Adolescents are easy targets for the tobacco industry, which profits handsomely from selling tobacco products to minors. Although the responsibility for luring children into tobacco use must be laid at the feet of the tobacco industry, the responsibility for preventing millions of dollars worth of illegal cigarette sales to Maryland children belongs to all of us. Maryland's cancer rate is unacceptably high, and tobacco accounts for 41% of all cancers in Maryland.[15] This fact alone establishes why we must be vigilant in protecting our children from the health hazards of tobacco use.

We should applaud those organizations, state and local, that are creatively working to stop youth access to tobacco. Approaches such as the one taken by Baltimore City in enacting an ordinance restricting billboard advertising by tobacco companies,[16] are measures that may prove effective in reducing the allure of smoking. The statewide workplace ban on smoking[17] also sends a powerful message about the dangers of smoking, and many young people who might otherwise be smoking at work will not be. These acts will help dissuade children from using tobacco. To reduce teen access to cigarettes and other tobacco products and to decrease teen smoking rates, however, we need to take the three steps outlined above: establishing license sanctions; restricting vending machines; and giving the health departments and

law enforcement personnel the tools they need to enforce the law.

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LETTER TO A FRIEND

February 1, 1995

Dear Jim,

I have heard that you are messing around with cigarettes. I hope this is not true! I know that peer pressure is hard to fight, but you will be far better off if you can ignore it.

I can't believe that an athlete as good as you are would even think about smoking. And remember, cutting down on your "wind" is the least of the health problems you will have to face if you choose to smoke.

Just think of the example you will be setting for your brother Billy. I know that he is a pain when he tries to imitate you all the time. How would you feel if he imitates your smoking?

Do you remember my cousin John? His uncle is sick and doctors think he may have cancer, probably from smoking two packs of cigarettes a day.

You are my best friend! Please don't start smoking. I want to have you as a friend for life, not a life cut short by cigarettes!

Your friend,
Kenny Sterling

Ed. Note: Kenny Sterling is a student at Woodson Middle School in Crisfield, Maryland. His letter was presented at the 1995 Kids Day in Annapolis.

Tobacco excise taxes: stop children from starting!

Kevin Scott Ferentz, M.D.

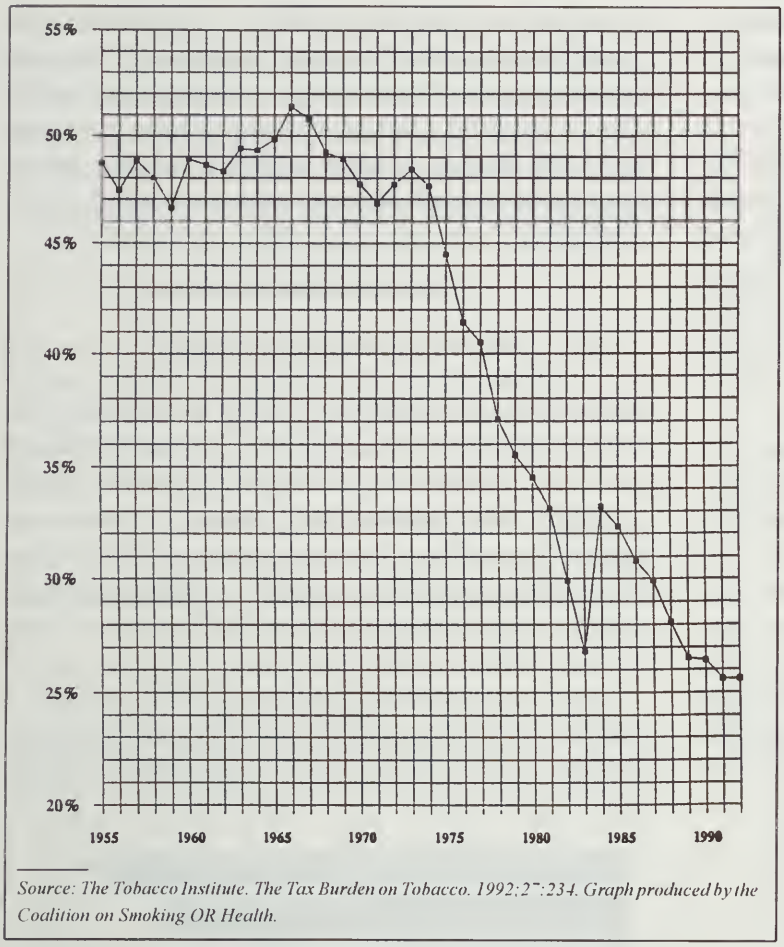
Dr. Ferentz is an associate professor in the department of family medicine at the University of Maryland School of Medicine.

Tobacco consumption continues to be the number one cause of preventable death in the United States. In addition to the more than 46 million American adults who smoke, nearly 3 million teenagers and children smoke.[1,2] More than 3000 young people—1 child every 30 seconds—start smoking every day.[3] As the number of adult smokers declines, the tobacco industry must appeal to young potential smokers to assure sales. The vast majority of current smokers began smoking by the age of 18. If a person does not begin smoking by age 20, it is unlikely he or she will ever smoke. Therefore, if we can discourage young people from ever starting we will have a great impact on the number of future adult smokers. One strategy that will do this, and thus prevent future disease, is to increase taxes on tobacco products.

Smoking rates

The prevalence of smoking has not declined among American high school seniors since 1980.[4] Data from the Maryland Department of Education's Adolescent Drug Survey show some alarming trends for our state. From 1988 to 1992, both cigarette and smokeless tobacco use increased in all grades. Almost 1 in 20 sixth graders smoked cigarettes within the 30 days prior to the survey. That number escalated to almost 1 in 3 twelfth graders. The use of smokeless tobacco has also risen sharply; more than 8% of high school seniors use these products. Because the rates of tobacco use are consistently higher in those not attending high school, these numbers represent the lowest estimates of users among our adolescent population.

According to the Maryland Behavioral Risk Factor Survey from the Department of Health and Mental Hygiene, the prevalence of smoking in Maryland decreased overall from 1986 to 1989 (28.7% to 22.8%). The rate then stayed constant from 1989 to 1991. In the spring of 1992, the Maryland legislature enacted a 20-cent per pack increase in the tax on tobacco (before the increase, the tax was 16 cents per pack). The tax



Source: The Tobacco Institute. The Tax Burden on Tobacco. 1992;27:234. Graph produced by the Coalition on Smoking OR Health.

Figure 1. Average U.S. cigarette tax as a percentage of retail price

increase went into effect July 1, 1992. The smoking prevalence rate for the first 6 months of 1992 was 23.4%. During the six months following the tax increase, the rate dropped considerably, to 18.3%. The overall rate of smoking in 1992 was 20.9%, the lowest rate recorded since 1986. The tax increase appears to have stimulated a drop in the smoking rate, which had become stagnant for a number of years.

The drop in smoking rates occurred across almost all socio-demographic characteristics, including gender, race, age, level of education, employment status, marital status, and income. The largest declines were seen in men, non-whites, and those aged 35 and older. The smallest decrease was seen in white females.

Considering these data, it would appear we can make inroads in the problem of smoking in our state by advocating for higher taxes on tobacco products.

Arguments in favor of increased taxes

Decreased consumption. A number of important scientific bodies have recommended increasing tobacco taxes to discourage youth tobacco use. In 1994, the National Academy of Sciences published a report[5] advising a $2 per pack tax increase. The report stated, "Pricing policy is perhaps the single most important element of an overall comprehensive strategy to reduce tobacco use, and particularly to reduce use among children." It also stated, "If tobacco is made less affordable... consumption will tend to decline, especially among children and youth, whose smoking habits are not firmly established."

It has been estimated that each 10% increase in the price of a pack of cigarettes would cause tobacco use to fall by 3% to 5%. The Coalition on Smoking OR Health has calculated that a $2 increase in taxes would result in 7.6 million fewer smokers and prevent 1.9 million premature deaths.[6]

In 1992, the National Cancer Institute convened an expert panel to review the literature on the impact of taxes on smoking behavior. The panel stated, "...increasing cigarette excise taxes may be the most effective single approach to reducing tobacco use by youth." Increasing taxes should both encourage teen and child smokers to stop as well as discourage children from ever starting. To prevent smoking among youth, the panel also recommended mass media campaigns, enforcing laws banning the sale of cigarettes to minors, clean indoor air policies, and school programs that teach young people how to avoid cigarettes. The panel also strongly recommended regular increases in the excise taxes on tobacco to keep pace with inflation.[7]

There is evidence that price influences youth tobacco consumption at least as much as it influences adult consumption, and maybe more. Each 10% increase in cigarette prices is estimated to reduce demand among children and teenagers by as much as 14%. Because adolescents are less likely to be addicted to tobacco and have less disposable income, they are more likely to give up buying cigarettes when prices increase.[8] The tobacco industry, however, often responds to tax increases by making lower cost generic cigarettes available and by reducing the price on premium brands to dilute the effect of the tax increase on sales.

It is also important to stress the need to increase taxes on all tobacco products, including smokeless tobacco, which many young people think is a safe, inexpensive alternative to smoking. Smokeless tobacco is highly addictive and is a significant cause of cancers of the mouth, gums, tongue, and throat. As many as 3 million Americans under age 21 use smokeless tobacco, including 1 of every 5 males in high school.[6] Maryland currently has no tax on chewing tobacco.

Increased revenue. Concern has been voiced, primarily by lobbyists and tobacco farmers, that raising taxes will reduce consumption and therefore decrease total tax revenue. That has not been the experience in Canada, where taxes on cigarettes increased dramatically from 1982 to 1992.[6] Taxes jumped 167% (the equivalent of approximately $3 per pack) and revenue from the increased taxes rose 71.4%. During that period, smoking declined 38% and youth smoking declined more than 60%. It is a situation in which everyone wins: because the percentage drop in consumption is less than the percentage increase in prices, fewer people smoke and more money is raised.

In California since 1989, when the state raised the tax from 10 cents to 35 cents per pack, smoking has declined 28%, more than 3 times the national rate of decline. At the same time, annual state revenues nearly tripled.

Data from Maryland indicate a similar trend.[9] The state instituted its first tax on cigarettes in 1958. Gross state cigarette taxes for 1959 were more than $1 million. By 1994, two years after our last tax increase, cigarette taxes brought $142 million to the state treasury. During that time, per capita sales in packs dropped from a high of 144.8 in 1974 to a low of 80.8 in 1994.

Taxes, for the most part, are not the reason for increasing costs of tobacco products. In 1966, state and federal taxes represented 51% of the retail price of cigarettes in the United States. In 1992, the tax represented only 26% of the retail price.[6] Therefore, the increase in taxes has been much smaller than price increases charged by the tobacco industry. When inflation is taken into account, taxes on tobacco products have actually fallen, in real terms, since 1955.[5] Tobacco industry revenue, however, has risen sharply (**Figure 1**).

Public support. In a recent poll, approximately 76% of Marylanders favored an increase in the state tax on a pack of cigarettes if the monies were used to cover health programs, including those to reduce or prevent cigarette smoking.[10]

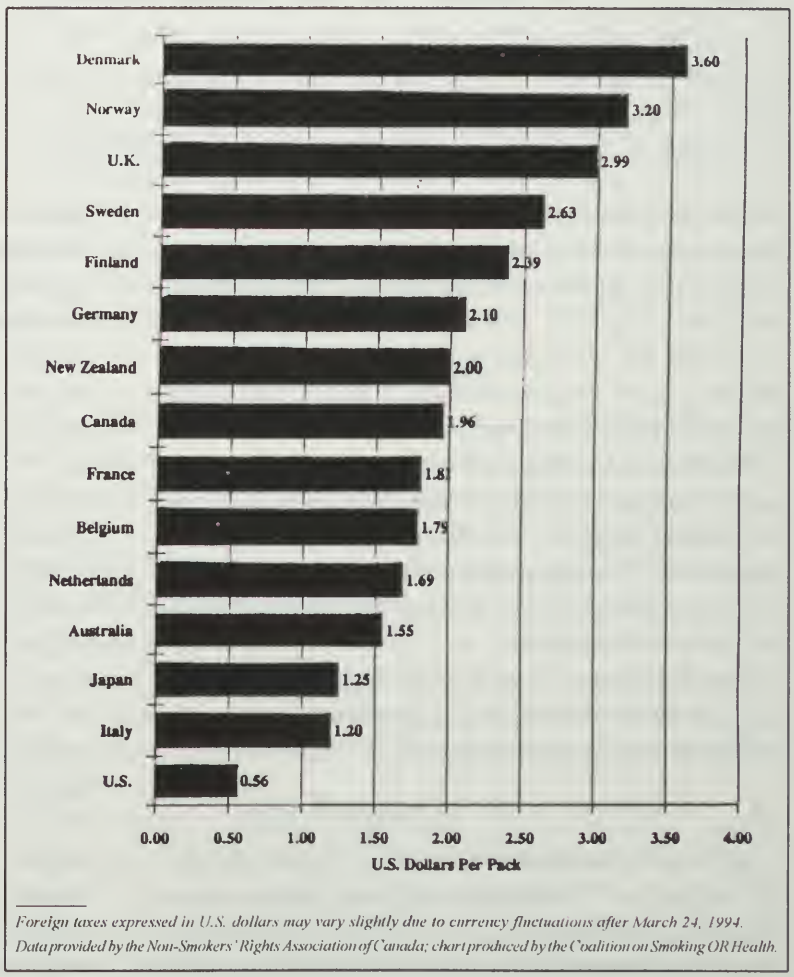
A national poll taken in April 1993, showed that two thirds of American voters favored a $2 per pack increase on cigarettes.[11] Taxes on tobacco in the United States are the lowest among the developed countries in the world (**Figure 2**).[12] Maryland's current state excise tax lands squarely in the middle of other states. Virginia has the lowest (2.5 cents per pack) and Michigan the highest (75 cents per pack).

There is no question that the general public favors limiting minors' access to tobacco. A recent random national household survey showed most respondents favored all proposed measures to restrict youth access to tobacco. These measures included fines for sellers, fines for youthful violators, licensing all tobacco vendors, restricting cigarette vending machines, banning tobacco sponsorship of youth-oriented events, banning all tobacco advertising, and increasing cigarette excise taxes.[13]

Fighting the tobacco lobby

Raising taxes can be difficult in state legislatures. After years of failing to pass tax legislation in California, a grassroots movement succeeded in placing an initiative on the ballot in 1989. The proposal, which increased taxes from 10 cents to 35 cents per pack, also included a provision that set aside 20% of the revenues from the new tax for tobacco use prevention programs. Despite a massive effort by the tobacco lobby, the initiative passed. A similar initiative in Massachusetts, which raised taxes from 26 cents to 51 cents per pack, passed in 1992.

There are no credible arguments against raising taxes on tobacco, yet the tobacco industry has made many attempts to dissuade legislators from enacting such legislation and from



Foreign taxes expressed in U.S. dollars may vary slightly due to currency fluctuations after March 24, 1994. Data provided by the Non-Smokers' Rights Association of Canada; chart produced by the Coalition on Smoking OR Health.

Figure 2. Cigarette taxes in major industrialized nations

using the money raised to educate the public about the hazards of smoking. Since California increased its tax, political expenditures by the tobacco industry have risen ten-fold in California, from $790,050 to $7,615,091. This influence has led to the under-funding of the tobacco education programs.[14] The tobacco lobby argues that decreased consumption leads to decreased revenue, an allegation that has been disproved time and again.

Multipronged approach needed

Raising taxes must be only one part of a multifaceted approach to decreasing smoking and other tobacco use. The ban on smoking in public places, antismoking advertising (especially by celebrities of importance to our youth), restricting and punishing sales to minors through vending machines, limiting free distribution of cigarettes, and other tactics must continue if we are to decrease substantially the number of smokers in our society.

To survive, the tobacco industry will continue to recruit teenagers and young adults to become new smokers. Young people often have a sense of immortality that unfortunately limits the effectiveness of messages about the health effects of smoking. A recent study in Canada showed that, despite the efforts of health educators, few young people knew smoking causes heart disease and many did not know lung cancer is fatal.[15]

Conclusion

Raising taxes on tobacco products will prevent addiction to tobacco products among many young Marylanders and thus decrease health problems in our state now and in the future. It will also raise money that can be used to continue to educate Marylanders about the dangers of tobacco use. Organized medicine can play a critical role in battling the tobacco lobby and influencing the legislature to enact these crucial measures. In doing so, we can proudly help the next generation avoid the negative health effects and years of lost life that are invariably associated with tobacco use.

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Maryland restricts workplace smoking

Elaine Patrick, J.D.

At the time this paper was written, Ms. Patrick was an assistant attorney general for the State of Maryland.

On March 27, 1995, Maryland enacted one of the most protective restrictions in the country on workplace smoking. The restriction had as its genesis a regulation promulgated by the state Commissioner of Labor and Industry[1] and approved by the Maryland Court of Appeals, the state's highest court.[2] That regulation was designed to protect workers in Maryland from the adverse health effects of environmental tobacco smoke (ETS). It would have applied to virtually every indoor place of employment and required an employer either to prohibit indoor smoking or to confine it to a specially ventilated area. In its 1995 session, the Maryland General Assembly enacted legislation amending the Commissioner's regulation.[3] The legislation exempted from the regulation bars and taverns; private, nonprofit clubs; and a percentage of hotel and motel sleeping rooms. It also changed the requirements for smoking areas in restaurants and certain other hospitality-type establishments. As Governor Glendening noted upon signing the legislation (a compromise between the executive and legislative branches), the combined effect of the legislation and the regulation is to protect 95% of Maryland employees from ETS—a substantial gain in employee protection.

With these actions, Maryland joined the handful of states (California, Vermont, and Utah) that have implemented broad restrictions on smoking to protect nonsmokers from ETS.[4] Even among this small group of states, however, Maryland's action is unique. It is the only state that used the regulatory process in adopting a broad smoking restriction. (Washington State has used regulatory authority to implement smoking restrictions, but those restrictions apply only to offices and not to workplaces generally.[5])

One prevalent misconception about the regulation is that it was adopted by "bureaucratic fiat." This phrase is apparently meant to suggest that with the stroke of a pen and without genuine consideration of the

scientific evidence regarding ETS and the views of the various interest groups and the public, the Commissioner adopted a far-reaching restriction on smoking. The same claim was raised in the lawsuit challenging the regulation. Maryland's highest court rejected it, finding that the regulation arose from a "comprehensive" rule-making proceeding that included several public hearings, "a great deal of live testimony," "a multitude of documentary evidence," and two detailed reports evaluating the evidence and explaining the Commissioner's reasons for adopting the regulation.[6] This article reviews the process that led to enactment of the regulation and emphasizes the scientific evidence that was before the Commissioner and his evaluation of it.

Authority to regulate

As a general rule, a government official, such as the Commissioner of Labor and Industry, may adopt regulations as permitted by the official's enabling act, the statute vesting the official with authority. If adopted according to prescribed procedures and within the boundaries set by the enabling act, the constitution, and certain other sources of law, the regulation has the force and effect of a law.[7] In adopting the smoking regulation, the Commissioner acted under the Maryland Occupational Safety and Health (MOSH) Act.[8] That statute permits the Commissioner to adopt regulations protecting employees from workplace conditions that constitute a significant risk to their health.[9]

ETS a significant health risk

Based on an extensive evaluation of the scientific literature regarding the health effects of ETS and the testimony of numerous experts in the field, the Commissioner concluded that occupational exposure to ETS increases the risk of lung cancer and heart disease sufficiently to constitute a significant risk to employee health. The Commissioner found that the scientific evidence before him showed ETS causes annually approximately 2200 lung cancer deaths in nonsmokers in the United States and that workplace exposure increases a nonsmoker's lifetime risk of lung cancer by about 1 per 1000. (The Commissioner published[10] a decision explaining his analysis of the evidence regarding ETS and his reasons for adopting the regulation in the *Maryland Register*, an official publication of the state through which administrative agencies give legal notice of certain actions.) The Commissioner further found, based on the scientific evidence presented during the rulemaking proceeding, that workplace exposure to ETS increases the workforce's lifetime risk of heart disease by at least 1 per 1000 and perhaps by as much as 12 to 21 per 1000.[10] The Commissioner viewed these increases in risk as significant and hence subject to regulation under the MOSH law.

Literature and testimony

Lung cancer. The Commissioner obtained the literature and testimony upon which these conclusions were based in a two-step proceeding that spanned nine months. More than 100 witnesses testified and interested parties submitted tens of thousands of pages of documents, including published epidemiologic studies of ETS, literature reviews, and critiques of the studies and reviews. With respect to lung cancer, the Commissioner received several comprehensive literature reviews and analyses,[11-13] including the most recent study on the matter, a comprehensive prospective study.[14] He also heard testimony from the project officer for the Environmental Protection Agency (EPA) report, Dr. Stephen Bayard, who described the EPA's methods of analysis and conclusions. Dr. Elizabeth Fontham testified regarding her study and its results.[14]

The Commissioner found that the reports by the Surgeon General, National Research Council (NRC), and EPA, as well as the Fontham study, all identified, with varying degrees of certainty, a connection between exposure to ETS and lung cancer. As the most recent and comprehensive works on the subject, both of which had been subjected to peer review, the EPA report and the Fontham study were of particular significance. In addition to evaluating the composition of ETS, the EPA reviewed studies of ETS levels in various public buildings and residences and approximately 30 epidemiologic studies of ETS and lung cancer. The EPA concluded that the epidemiologic studies show a causal association between exposure to ETS and lung cancer in nonsmokers.[13] It also conducted a risk assessment and concluded that the relative risk for lung cancer from nonspousal exposure to ETS is 1.34, which translates into approximately 2200 lung cancer deaths annually in the United States.[13] Fontham reported that occupational exposure to ETS yields a relative risk for lung cancer of 1.39.

A major issue before the Commissioner was the scientific validity of these works. Philip Morris Companies, Inc., a cigarette manufacturer, and other interested parties particularly challenged the reliability of the EPA report. The primary claims were that

- the EPA report was not subjected to genuine peer review because the panel that reviewed it was not truly independent of the EPA;
- the EPA violated accepted principles of scientific analysis by using meta-analysis on various epidemio-

logic studies on ETS and lung cancer and by applying a one-tailed, as opposed to a two-tailed, test for statistical significance;

- the EPA did not correct appropriately for misclassification of smokers as nonsmokers; and
- had the EPA considered certain very recent studies on ETS and lung cancer, its results would have been different.[10]

The Commissioner considered each of these challenges. With respect to the alleged lack of genuine peer review, the Commissioner had before him the testimony of Samuel Rondberg, a staff member to the EPA's science advisory board. Rondberg testified that the EPA convened a panel of 18 non-EPA scientists (the SAB) to review the report. The panel conducted two public hearings on the report and issued two written evaluations of it, which Rondberg presented. The written evaluations showed that the SAB was unanimous in endorsing the conclusion that the epidemiologic studies support a causal association between exposure to ETS and lung cancer and that it viewed the quantification of risk to be reasonable.

Rondberg further testified that the EPA typically assembles panels of outside scientists to review agency work and when doing so, the agency seeks to ensure that the panel is unbiased and impartial about the issue. He testified he believed the EPA had achieved this goal for the SAB that reviewed the ETS report, noting that during the review process, both the tobacco industry and anti-smoking groups had claimed the SAB was biased against their respective positions and that some members of the SAB had performed paid consulting work for the tobacco industry. These facts persuaded the Commissioner that the SAB was sufficiently independent of the EPA and its work sufficiently complete and expert for its review to be regarded as reliable.

The remaining challenges to the EPA report went primarily to the validity of the agency's methodology. The Commissioner noted that most of the claims had been raised to, and rejected by, the SAB, suggesting they had little merit. The Commissioner further noted that the degree of consistency between the EPA report and the earlier reviews by the Surgeon General and the NRC tended to show the EPA's results were not attributable to flawed science. In addition, the Commissioner noted the striking similarity between the EPA's conclusions and the Fontham study. Based on the testimony of Dr. Fontham regarding her study, the Commissioner deemed it entitled to considerable weight. It was a very large, prospective study and conducted with great care. That it would report results so similar to those found by the EPA fostered confidence in the EPA's work.[10]

In addition, Dr. Bayard submitted to the Commissioner responses to the various challenges raised to the EPA's methods, which the Commissioner found to be detailed and persuasive. With respect to the argument that the EPA should not have applied meta-analysis to the various epidemiologic studies, Bayard explained that meta-analysis was only one of several methods by which the EPA evaluated the studies on ETS and lung cancer and that all methods yielded similar results—ETS exposure increased the risk of lung cancer. The Commissioner particularly noted Bayard's testimony that the EPA also determined the probability that the consistency in the epidemiologic literature on ETS and lung cancer—linking ETS to lung cancer in nonsmokers—was the result of chance. Bayard testified that of the 30 studies, 24 found an increased risk, 9 of which were statistically significant, and that the probability of this occurring by chance was less than 1 in 10 000. He further testified that 17 of the studies reported results by exposure level and that all 17 reported an increased risk in the highest exposure group, with 9 of these being statistically significant. The likelihood that all 9 would be statistically significant as the result of chance was less than 1 in 10 million. Bayard finally testified that 14 of the studies had sufficient data to test for whether increasing exposure was associated with an increasing incidence of disease (an exposure-response relationship). Of these, 10 showed a statistically significant exposure-response relationship. The odds that this would happen by chance were less than 1 in one billion.[10]

With respect to the claim that the EPA should have used a two-tailed, rather than a one-tailed, test for statistical significance, the Commissioner found persuasive Bayard's explanation for the EPA's choice. According to Bayard, the EPA selected a one-tailed test because, based on the well-established dose-related relationship between direct smoking and lung cancer and the qualitative similarities between ETS and direct smoke, the EPA was able to form an hypothesis about the expected result of its review—that ETS increased the risk of lung cancer—and hence used a one-tailed test.[10] The Commissioner also found persuasive Bayard's explanation that the EPA omitted two studies[15,16] because they were published after its cutoff for accepting literature, but that they, like the subsequent Fontham study, were consistent with the EPA's conclusions.[10]

Heart disease. With respect to heart disease, the Commissioner likewise considered published reviews of the literature,[17-19] the epidemiologic studies of the relationship be-

tween ETS and heart disease,[20-30] and expert testimony interpreting that literature and quantifying the risk. Based on that evidence, the Commissioner concluded that workplace exposure to ETS increases the workforce's lifetime risk of heart disease by as much as 12 to 21 per 1000. Daniel Ford, M.D., M.P.H., (an assistant professor at The Johns Hopkins University School of Medicine, department of medicine, division of internal medicine, Welch Center for Prevention, Epidemiology, and Clinical Research and The Johns Hopkins University School of Hygiene and Public Health, departments of epidemiology and health policy and management) testified regarding the literature on heart disease and ETS. He described the body of literature on the issue as fairly large, comprising studies of different design, done in different countries, and across different age groups and both sexes.[10] He testified that for all the studies to report positive results showed a degree of consistency sufficiently "marked" to give confidence to the conclusion that ETS increases heart disease risk. He also testified that there is considerable evidence showing this conclusion to be biologically plausible.[10]

Walter Stewart, Ph.D., M.P.H., (an associate professor of epidemiology at The Johns Hopkins University School of Hygiene and Public Health, departments of epidemiology, environmental health sciences, and occupational and environmental epidemiology) quantified the risk of heart disease that ETS presents to the workforce. He testified that if workplace exposures were identical to spousal exposures, the excess risk would be 21 per 1000 over the lifetime of the workforce. He further testified that if overall workplace exposures were substantially lower than spousal exposures, they would still yield excess heart disease death over the lifetime of the workforce at a rate of at least 1 per 1000, which is legally accepted as constituting significant risk.[10]

As with the evidence regarding lung cancer, the Commissioner heard considerable dispute regarding the validity of the scientific evidence that ETS contributes to heart disease. Philip Morris, Companies, Inc., submitted extensive written criticisms of the epidemiologic studies. It challenged the methodology of many of the studies and claimed that those reporting an increased risk of 1.2 or higher must be in error because that level of risk is implausibly high when compared to the increased risk of heart disease associated with direct smoking. It also presented Dr. Domingo Aviado as a witness. Dr. Aviado presented a book chapter[31] he had written in which he challenged the biological plausibility of an association between ETS and heart disease on the grounds that ETS concentrations are too low to present any genuine health risk.

The Commissioner considered and rejected the challenges to the studies linking ETS and heart disease. With respect to the alleged flaws in methodology, the Commissioner found, based on the literature itself and expert testimony, that the criticisms did not detract from the reliability of the studies.[10]

Regarding the claim that the relative risk reported in these studies was implausibly high when compared to the relative risk for direct smoking, the Commissioner was persuaded by Dr. Ford's testimony and by published reports[13,32] that there are a number of scientifically sustainable explanations for the similarity. For example, exposure of a nonsmoker differs qualitatively than exposure of a smoker.[13] The smoker experiences chronic effects while the nonsmoker experiences acute effects.[10] The Commissioner also rejected Dr. Aviado's claim that ETS concentrations are too low to present a risk of heart disease, noting that Aviado's theory made no mention whatsoever of nicotine, one of the prime suspects for tobacco-related heart disease. In addition, the Commissioner noted that Aviado looked only at a handful of the components of tobacco smoke and assessed their health effects in a manner that did not account sufficiently for their simultaneous presentation in ETS. The Commissioner viewed this approach as not giving an accurate picture of the health effects associated with ETS.[10]

Conclusion

Based on all the foregoing as well as additional evidence indicating that the studies of ETS were appropriately viewed as reflecting the likely outcome of occupational exposure,[10] the Commissioner determined that ETS in the workplace constituted a sufficient risk to employee health to warrant restriction.

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CIGARETTE USE (PERCENTAGES) AMONG 8TH, 10TH, AND 12TH GRADERS

	8th Graders			10th Graders			12th Graders		
	1992	1993	1994	1992	1993	1994	1992	1993	1994
Lifetime	45.2	45.3	46.1	53.5	56.3	56.9	61.8	61.9	62.0
30-Day	15.5	16.7	18.6	21.5	24.7	25.4	27.8	29.9	31.2
Half-pack+ per day	2.9	3.5	3.6	6.0	7.0	7.6	10.0	10.9	11.2

Source: National Institute on Drug Abuse 1994 Monitoring the Future study. Reported in *NIDA Notes*, March/April 1995, p.15.

Fighting cigarette vending machines

MAX LESKO and MORGAN LESKO
Max Lesko is a 6th grade student and Morgan Lesko is an 8th grade student at Tilden Middle School in Rockville, Maryland. Recognizing them as "cigarette vending machine killers," President Clinton invited them to Washington, DC, for his August 10 announcement that he instructed the FDA to regulate tobacco marketing to young people.

It all started when we were in the car on our way to soccer practice back in 1991. We heard on the radio that there was going to be a hearing on a proposal to ban cigarette vending machines in Montgomery County. The news story sparked an idea that we could buy cigarettes from vending machines. We were really young back then: 9 years old (Morgan) and only 6 years old (Max). Both of us already knew that tobacco products were bad. When Morgan was in first grade, he signed a pledge for the Smoke-Free Class of 2000. We decided that this ban would protect the community and most importantly, the children in it. We carried out a sting operation, and for the first time in our lives, we testified in front of elected officials. From that point on, our testimony has led to more testimony at the state level. Although the tobacco lobbyists have won most of the battles with all their money and free gifts that they give to legislators, we have come awfully close a few times and we'll keep trying until we succeed. In this article, we try to share with you what we have learned on our journey so far.

The following is a series of steps that we feel are necessary to take when attempting to make maximum change.

Target a topic. Our first piece of advice is to choose a topic that you really believe is important. For us, we pinpointed what we were going to focus on when we heard the news on the radio. We knew we were concerned about tobacco and its effect on youth, but it would be almost impossible to solve this whole problem with one blow. So our common sense brought us to the proposed solution of a cigarette vending machine ban because these machines are easy targets for minors.

Find the power. Next, you must find a way for your idea to be nurtured. Often the most obvious answer is your local or state government. Although we had never heard of a county council, we found out about it from the same radio clip. This information guided us to the Montgomery County Council in Rockville, Maryland. A call to the Council gave us the date and time of the hearing as well as the rules for testifying. Now we knew who had the power to make it happen. We only had about two weeks until the hearing so we got right to work. We needed more than words to convince the Council how easy it is for kids to buy cigarettes from vending machines.

We planned a sting. We plotted out where we were going to try to buy cigarettes. At that time we did not have to worry about getting caught with cigarettes because the law only made it illegal to sell to minors. Our first sting operation was at a restaurant called Big Boys. We were very worried that someone was going to stop us. We quietly put the quarters in and got a pack of Camels and no one said a word. In the next few days, we bought two more packs without any trouble. After we bought each pack of cigarettes, our mom or dad would reappear to take a Polaroid photo of us holding the cigarettes in front of the vending machine. This evidence proved what we said was true.

Write good testimony. Then it was time to write the actual testimony. We only had two minutes to convince the County Council. Our short speech was only about 400 words or one double-spaced page. Using a computer makes it so easy to write a speech, revise it, and produce multiple copies. (Spellcheck helps a lot.) From our experience, we think it helps to tell specific stories and not just roll off statistics. The following is a part of our testimony that the Council and the audience seemed to enjoy the most:

> That night we went to the bowling alley and there was another vending machine. It was wide in the open. I was very scared but Max wasn't. He put the quarters in but they got jammed. Then we went up to this kid named Jeff who is a 9th grader at Walter Johnson High School. I knew him from basketball. We

told him what we were trying to do about getting rid of vending machines. He thought it was a great idea. Then we asked him if he would help us by buying cigarettes. He said, "Sure," and did it perfectly. He just went right up to the machine with his back to about 20 people but no one cared. That night Max and I learned how to get the cigarettes easily.

Using a dab of humor helps keep lawmakers attentive. This story was not meant to be funny but when they heard it, they really responded. The lesson here is you cannot just tell jokes but a bit of comic relief does the trick.

Even though we are too old for show-and-tell in school, we use this powerful technique each time we testify. Visuals seem to allow lawmakers to kind of participate in what you are saying. Along with our testimony before the Montgomery County Council, we organized all our evidence on a big piece of red poster board. We included the packs of cigarettes we bought and the photographs of us in front of the vending machine. Also, we labeled the exact locations for each grocery store, restaurant, bowling alley, hotel, etc., where we conducted our sting. Another time when we testified in support of a tax on chew and spit tobacco in Annapolis in 1995, we made a small poster which we titled "The Good, The Bad and The Ugly." Again we tried to combine information with humor. Here is a sample:

> This is the GOOD, the BAD, and the UGLY. This bubble gum called Big League Chew is the GOOD because hopefully kids will buy this instead of the tobacco. Also in the GOOD column, we have put in Senate Bill 621. The BAD are these pamphlets for things like harmonicas and headphones that are made by the tobacco companies with their logo on them. Kids are attracted to these cool products. This is the BAD because you must have proof-of-purchases from tobacco to buy these things. The UGLY is this can of cherry dip and this package of chewing tobacco. These UGLY nicotine drugs seem pretty nauseating. We want you to know there is not a shred of Cherry Dip in the can or Big Red Chew in the pouch. As soon as we got home our mom threw it out and our whole house stunk until we took the garbage out.

A punch line is good to include in your testimony because it gives the legislators something to remember. Also it is good to include your catchy phrase whenever you are interviewed by the press. This gets your message out beyond the walls of the hearing room. Here's one example we came up with: "Sure they say cigarette vending machines are convenient—but they don't say for whom."

After you are done writing up your testimony and making your visuals such as a poster, it is very important to rehearse your testimony. You also should practice speaking loudly because the microphones often do not work very well. Another suggestion is to tape yourself. When you listen to it you might find a mistake that you didn't catch or parts that don't make sense. Have someone ask you questions that legislators might ask and practice answering. In our case, a question we were ready for was: "Aren't you guys breaking the law?" Often we get asked whether we know kids who smoke or use spit tobacco.

Get an ally. It is a big help to have a legislator who is your ally, especially if he or she is the sponsor of the bill. This helps because you won't feel like a stranger at the hearing. This also gives you a place to stay until your particular bill comes up in the hearing room, because sometimes you have to wait for hours. Your legislator can get reporters and TV crews at the hearing, which puts the spotlight on who the lawmakers are supporting. If they do look like they are on the wrong side, voters won't reelect them. Hopefully your ally will convince other legislators to vote on your side of the bill. This is why it is good to have a big-time supporter at the hearing that you go to.

Use the press. Before you head off to testify, make sure to fax a press release about what you will be doing. It's good to advertise your age if you are young because it's a different angle on the news. One time, we faxed our testimony to the media the night before going to Annapolis and minutes later, WTOP radio called to interview us over the phone. That story played many times and got other reporters interested. Early the next morning, one TV crew arrived at our house before we left for the Statehouse. They taped us making posters and they went to any length to get a picture. The cameraman wanted to get us at the computer when we were making copies of our petition in support of a House bill that would have banned cigarette vending machines. When the petition came out of the printer it was face down. They wanted to get a

close-up shot of the type so we printed our petition on the back side too. Our purpose for giving all these details is to emphasize how important visuals are to reporters. We also have had luck faxing our testimony to weekly newspapers and several times they have reprinted our entire speech in Letters to the Editor. When you advertise, it brings reporters. And when reporters are around, it helps pressure lawmakers to vote for the good guys, not tobacco companies.

Be yourself. When you actually give your testimony, the most important thing is to be yourself because then you will be believed more. This is because they know you aren't paid to testify and if you are not flat-out silly, then they cannot say anything against you. Although we usually are not attacked, we do have our opponents.

An opponent we ran into in 1994 was the chairperson of the House Ways and Means Committee, Delegate Sheila Hixson. We went to Annapolis for the Maryland Lung Association's Lunch with Legislators. Afterwards we stopped to talk with some of our legislators in their offices as well as Delegate Hixson because we planned to testify before her committee the following week. She scolded us for what we were doing and said it was against the law. We didn't think she was right, but thought we should check before we contradicted her. Before we testified we did more research. We discovered that it was not illegal for minors to possess cigarettes (note: a law was passed later in 1994 which did outlaw possession of tobacco by minors). We made a photocopy of the Maryland law and presented it to her during our testimony. This worked because it gave her the message that she cannot protect the tobacco companies. It showed that we're not just dumb kids. In 1995, Delegate Hixson introduced a good bill banning cigarette vending machines that still would allow Montgomery County and other local communities to pass stronger laws than the state.

Face your opponents. Mr. Bruce Bereano is a lobbyist for the tobacco companies. He frequently makes remarks to us about missing too much school; not knowing the law; being put up to this by our parents; and telling adults what to do. We have found that to deal with people like this, you need to catch them off guard. During testimony, contradict what you know they will say about you. This way they will more likely be dumbfounded. For example, we expected that Mr. Bereano would tell the committee that we did not know the law, so in our testimony before the House Environment Committee in March 1995, we made it clear that we know minors are not allowed to possess tobacco products and that we flushed the cigarettes down the toilet right after we bought them.

We gave him a copy of our testimony and highlighted the words so he would know that we weren't stupid. He acted a little stunned. Because of opponents like this, we have to avoid using big words like "non-preemption" so it doesn't seem as though we were put up to this. Our parents have to make sure that they stress that they only encourage but do not pressure us to fight for good laws.

Keep up to date. We also think that it's important to stay in contact with people who really know what is going on. They can inform you about when hearings will be held, what time you have to get something done by, and other helpful pieces of information. They can also tell you what is happening behind the scenes so you know what to prepare and watch out for. For example, our senator, Chris Van Hollen, told us about his proposal to tax smokeless tobacco and when hearings would be held, and he made copies of our testimony to pass out to the Budget Committee members and the media.

Even when the Maryland legislature is not in session, we get news from people like Marcia Marks with the Maryland Coalition To Stop Illegal Sales of Tobacco to Minors, Inc., and others. These allies help keep us involved, especially when bills we are supporting get defeated year after year. Even though the cigarette vending machine ban passed by the Montgomery County Council was overturned by the Court of Appeals, we are still able to remember our victory because we were given the pens that County Executive Neal Potter used to sign the local ordinance. Lots of people let us know we shouldn't stop. One of our favorite lines is when former Council member Bruce Adams said, "These two guys slam-dunked all those high-powered lobbyists and interest groups that were fighting that legislation." Comments like that encourage us to continue fighting tobacco products.

We have kept up with this issue for five years and we plan to stick with it until all cigarette vending machines are out of Maryland so not as many minors will smoke and sooner or later die because of it. ■

A Look Back

1955:

- *Eisenhower suffers a heart attack*
- Damn Yankees *opens on Broadway*
- *The United States House of Representatives votes 394 to 4 to extend the military draft*
- *South Africa withdraws from UNESCO because of the group's pressure to end apartheid*
- *Like other medical publications,* Maryland State Medical Journal *carries a variety of cigarette ads*

Cigarette advertising

John W. Buckley, M.D.
Dr. Buckley is the editor of Maryland Medical Journal.

Forty years ago the country was smoking cigarettes at a great clip. Our heroes, leaders, role models—many smoked—athletes, Hollywood personalities, even doctors. And why not! A carton of cigarettes cost $2.00. "I Love Lucy" was sponsored by Philip Morris. Television announcers were sending countless Camels to servicemen.

In the 1950s, I was a teenager. Smoking was an adolescent rite of passage. To gain permission from our parents to smoke meant that we were adult, able to inhale like Humphrey Bogart. High schools even set aside smoking areas for upperclassmen. To smoke was to be grown up and to be grown up was to smoke.

But not everyone was promoting cigarettes. Parents discouraged the practice, even if they eventually accepted it. Anyone's grandmother could tell you, "It's not good for you." High schools might have had smoking lounges, but the athletic coaches forbade cigarettes.

If you want to look back, rent *The Seven Year Itch* at your video store. It didn't win any Oscars in 1955, but it is chock full of the 1950s. Tom Ewell fights with his urge to regain youth and excitement, tempted by Marilyn Monroe. He also struggles with his addiction to cigarettes. Like most New Yorkers with common sense, he employs all sorts of tactics to break the habit because he knows it's bad for him. (No civil suit against tobacco companies claiming innocence.)

How could medical journals advertise cigarettes in 1955? We physicians must have known, but not accepted, the truth.

For my own enjoyment, I pull an old book off a shelf at home to reread a portion. In between random pages is some off-white dust. It always surprises me and makes me sad, for it is the 40-year-old ashes from my father's cigarettes. He was a pediatrician and he knew better than to smoke. But he was always short of time, using books as ashtrays and ignoring his addiction to Chesterfields. He died at 63—brain mets from bronchogenic carcinoma.

This issue of *Maryland Medical Journal* may have many articles that say the same things, but they are all true and worth repeating. Should smoking be banned? Should tobacco be taxed away? Will legislation achieve better health? How can potential smokers be sold on the concept of not smoking? How to quit?

Perhaps every reader should look back, see the movie, think of a friend who has died from smoking, then renew the resolve to help family members, friends, patients to not smoke. ■



From *Maryland State Medical Journal*, Volume 4, Number 2, 1955.

It is common knowledge to the medical profession and should become so to the public that cancer of the lung is a potent danger in people over forty years of age, especially in the male sex. Since this condition ranks second only to carcinoma of the stomach in the male, the attention it has been receiving by the profession, internists and surgeons alike, is certainly warranted. Even though the extensive investigations that have been carried out during the last decade have not resulted in specific answers to such questions as etiology and prevention, they have served amply to stress the paramount importance of early diagnosis and early surgery.

From: Brantigan OC, Hadidian CY. Cancer of the lung. *Md State Med J* 1955;4:91-97.

COMING OUT OF THE DARK

Med Chi's Physician Rehabilitation Committee deals with the substance abuse and mental health problems of Maryland physicians, with a confidential and nondisciplinary focus...Addiction, Marital/Family Conflicts, Psychiatric Illness, Organic Impairment, Physical Handicap...If these problems exist, we can help find the solution. Call us.

The Physician Rehabilitation Committee of Med Chi is available to all Maryland physicians, and their families. The Committee is NONDISCIPLINARY and information is kept CONFIDENTIAL. If you, a colleague, or family member is in need of our services call (410)962-5580 or call toll free (800)992-7010, or leave a message 24 hours a day, 7 days a week at (410)727-1020.

HELPING IS OUR BUSINESS...All donations to the Physician Rehabilitation Committee are used for the delivery of services to Maryland physicians in need of help. If you wish to help further the work of the Committee through a tax deductible donation send your check to: The Medical and Chirurgical Faculty Charitable/Educational Foundation, 1204 Maryland Avenue, Baltimore, Maryland 21201 Please note on your donation: "Physician Rehab"

Medical and Chirurgical Faculty of Maryland

Physician Rehabilitation Committee

In Memoriam

Dexter Means Bullard, Jr., M.D., director of Chestnut Lodge Hospital in Rockville for 25 years, died of cancer on August 10, 1995, at Suburban Hospital. A native of Washington, DC, Dr. Bullard was a graduate of Yale University and earned his medical degree from the University of Pennsylvania School of Medicine. In addition, he was a graduate of the Boston Psychoanalytic Institute and completed his training at the Massachusetts Medical Center. A research fellow at Harvard Medical School, he later was chief of outpatient psychiatric services at Boston Children's Hospital Medical Center and Harvard University Medical School. After he returned to Washington, Dr. Bullard became director of Chestnut Lodge, succeeding his father, who had served as director for 38 years (Chestnut Lodge was founded by Dr. Bullard's grandfather in 1910). At Chestnut Lodge, Dr. Bullard designed the adolescent and child psychiatry center, initiated community outreach projects, and directed clinical drug trials. He was 66.

I-Chief Lee, M.D., an anesthesiologist at St. Joseph Medical Center in Towson, died of heart failure during surgery there on August 8, 1995. Born in Sumatra, Indonesia, Dr. Lee studied obstetrics and gynecology at the Taiwan University College of Medicine in Taipei. Upon completion of a residency in New Jersey, he studied anesthesiology at Albert Einstein College of Medicine in New York and completed a residency there. In 1973, he joined the anesthesiology department at St. Joseph and three years later the York Road Anesthesia Associates. He worked there until his retirement in 1987. Dr. Lee was a member of several professional organizations. He was 61.

Ernest W. Shervington, M.D., an internist in Baltimore for nearly 50 years, died in his sleep at the Keswick Home on July 22, 1995. Born in Antigua in the British West Indies, Dr. Shervington received his medical degree from Howard University College of Medicine and interned at Freedman's Hospital in Washington, DC. He began his practice in the mid-1930s and then served at Fort Bragg, North Carolina, during the Korean War; he was discharged with the rank of captain. Director of the Baltimore Health Department Venereal Disease Clinics from 1954 to 1970, Dr. Shervington was also chief of medical clinics at the old City Hospital from 1960 to 1970. In addition, he was a consultant to Church and Provident hospitals and the Maryland Division of Social Security Administration. In 1964, he became one of the first black staff physicians at Johns Hopkins Hospital. A fellow of the Royal Society of Health in London, the American College of Angiology, and the New York Academy of Sciences, Dr. Shervington was a member of many professional and community organizations. He was 89.

Gordon M. Smith, M.D., former chief of primary care at Soldiers and Airman's Home in Washington, DC, and an emeritus member of Med Chi, died of cancer on June 24, 1995, at his home in Urbana. A native of Washington, DC, Dr. Smith received his medical degree from George Washington University School of Medicine. During World War II, he served in the Army Medical Corps in Belgium and Germany, earning the rank of captain. After the war, he returned to his practice in Barnsville and is remembered as making house calls until his retirement. He was on the staff of Suburban and Frederick Memorial hospitals. Dr. Smith was a member of many professional societies, including the American Academy of Family Practice, the Frederick County Commission on Aging, and the Maryland State Health Compensation and Arbitration Board. In addition, he was a volunteer driver for the Red Cross. Dr. Smith was 76.

Anthony Stedem, Jr., M.D., a retired psychiatrist, died July 20, 1995, of cancer at Greater Baltimore Medical Center. Dr. Stedem received his medical degree from the University of Maryland School of Medicine and completed an internship at Mercy Hospital (now Mercy Medical Center). He was an officer in the Army Medical Corps and a resident in psychiatry at the Perry Point Veterans Hospital. He retired from his practice in 1982, but was a consultant to the Social Security Administration for the past 10 years and an active member of several professional organizations. A former assistant professor at the Johns Hopkins medical school, he had taught residents at the Sheppard and Enoch Pratt Hospital and the Phipps Clinic at Hopkins. Dr. Stedem was 75.

Jean Thorne-Brown, M.D., a specialist in emergency medicine, died August 14, 1995, at her home in Phoenix, Maryland, of complications of an asthma attack. Born in

Washington, DC, Dr. Thorne-Brown was raised in Hagerstown. She earned a degree in pharmacy at George Washington University in 1958, where she later returned for medical school, graduating in 1967. She served her internship and residency in internal medicine at Mercy Hospital (now Mercy Medical Center) and a surgical residency at Union Memorial Hospital. She was director of emergency medicine at what is now Harbor Hospital and also at Carroll County General Hospital. In 1983, she started Physicians Promptcare, an emergency and primary medical care service, in Perry Hall and Abingdon. A member of the American Association of Ambulatory Care Centers and the American College of Emergency Physicians, Dr. Thorne-Brown was 59.

Daniel G. Wehner, M.D., a general surgeon, died July 7, 1995, at St. Agnes Hospital in Baltimore after a long illness. Dr. Wehner received his medical degree from the University of Maryland School of Medicine and completed his internship and residency at St. Agnes Hospital. He became a member of the medical staff there in 1940, and eventually became vice-president. In addition, Dr. Wehner served as medical director for the United States Fidelity and Guaranty Company. Dr. Wehner was a member of several professional organizations, including the American Society of Abdominal Surgery and the American College of Surgeons. He was 84.

No additional information was available at press time for the following members:

Robert L. Baker, M.D.
Wicomico County ..... July 5, 1995

Young E. Chun, M.D.
Affiliate

Albert J. Fisher, M.D.
Prince George's County ..... July 13, 1995

John S. Haines, M.D.
Baltimore City ..... June 5, 1994

Walter E. E. Loch, M.D.
Baltimore City

Med Chi Bicentennial Celebrations

Med Chi has already begun planning celebration activities for its bicentennial in 1999. If you have ideas or suggestions, please call Margaret Burri or Vivian Smith at 410-539-0872 or 1-800-492-1056.

Alliance

Alliance Committee on Domestic Violence

As chairperson of the newly formed Alliance Committee on Domestic Violence, I am excited and eagerly looking forward to working with each Alliance chapter in Maryland. In 1995-1996, we face many challenges, not only on the state and national levels, but on the county level as well. Having been involved in many aspects of domestic/family violence since 1974, I am especially cognizant of the hurdles that lay ahead as we move toward the year 2000. It is the responsibility of each of us to do our part in making this nation "more gentle and kind" to all of its citizens. This does not mean cultivating a climate of dependency and irresponsibility on behalf of the victims; it means addressing and finding solutions that are attainable by all.

Many communities have taken up the gauntlet of improving and enhancing services for all victims of domestic/family violence. We, as communities, have begun the vital task of collaborating and networking with various existing programs and projects. This is a *major* variable now that federal and state monies are shrinking. We need to become more thoughtful and creative in assessing our local problems and solutions. We need to be critical and deliberate in reevaluating the strengths and limitations we witness within each jurisdiction. In continuing to develop and implement a systematic and comprehensive plan for each county within the state, we:

- are serving to raise the level of awareness as to the prevalence of domestic/family violence in the community;
- are educating each sector of our society that can and does impact on the resolution of this serious health issue;
- are empowering the victims to assert themselves in more positive and constructive ways that protect themselves *and* their children;
- will be interrupting a very dysfunctional pattern of interrelating with family members that has far-reaching and devastating consequences;
- will be intervening and creating an environment in which healing can begin; and
- will be rearing children who will be compassionate, healthy, and productive citizens.

In Montgomery County alone, reported domestic violence incidents rose from 486 in 1984 to 1558 in 1993, a 220% increase. With an estimate of 35% to 50% of women experiencing domestic violence some time in their lives, many more incidents remain unreported due to the associated social stigma. Yearly, 1 to 7 out of a total of 21 to 35 homicides in our county were the result of domestic violence (1989 through 1994 data).

According to the National Woman Abuse Prevention Project, "Children in homes where domestic violence occurs are physically abused or seriously neglected at a rate 1500% higher than the national average." Children raised in such homes have a substantially higher risk of committing sexual assaults, property crimes, and assaults; abusing drugs and alcohol; and suffering from other behavioral and learning problems as juveniles. As adults, they are more likely to be involved in domestic violence situations as either abusers or the abused, as well as to populate the adult correction institutions. It is clear that if we are serious about reducing crime and the astronomical health care, economic, and human costs as results of domestic/family violence, we must treat domestic violence as a *top public safety and public health concern* and address this concern *early* in the most proactive and aggressive way. Domestic/family violence impacts on *each* of us, directly or indirectly. And, only we can stop the violence!

Med Chi and its Alliance have been addressing the issue of domestic/family violence for the past several years. Together, we have accomplished some incredible feats:

- Developed a comprehensive and informative training manual for physicians and other health care professionals.
- Raised and donated monies to area medical schools to help educate young medical students about the prevalence and underlying dynamics of domestic/family violence.
- Initiated and developed programs to help the counties begin to address this devastating problem by dispersing information and pamphlets, participating in health fairs, etc.

- Mobilized community support by participating on task forces, coalitions, etc., that address domestic/family violence.
- Mounted statewide legislative initiatives and supported and lobbied ongoing legislation that speaks to intervention in prevention of domestic violence.
- Supported shelters and various community projects.
- Raised awareness and educated the communities through public service announcements and other advertisements.

At this time, however, although we are committed to addressing this epidemic of violence in our nation, we are faced with a serious dilemma. As we raise awareness and educate our communities, we increase the need for services. In this current economic slump, we do *not* have services in place to meet the rising demands of our citizens. Our staffs, our present programs are woefully inadequate. The major questions are:

- How do we *best* serve our communities?
- How do we prioritize the numerous and urgent needs that exist within each county?
- How do we *better* utilize existing services to meet the rising demands of our communities?

During the next year, the mission of this newly formed committee will be to assess the status of programs that exist or have existed in each county. During the past spring, I wrote to each Alliance chapter asking it to evaluate the current state of domestic/family violence programs in its county. Some counties have viable and successful programs; other counties must share services among each other. Our goal during the next 5 to 10 years is to bring each county up to parity. By doing a comprehensive needs assessment, we can begin to develop strategies that address the strengths and limitations that exist within each county. I am very *realistic*. It will not be accomplished overnight. There will be numerous setbacks, obstacles, and challenges that must be met. However, by formulating short- and long-term goals and organizing our energies and resources, we can accomplish much. We must not continue reinventing the wheel. An incredible amount of knowledge, information, and resources are available; we just need to know how to access them to meet each county's individual needs.

I see that my purpose as chairperson of this committee will be to help each county organize and develop strategies to meet these needs. Each county has its own personality, strengths, weaknesses, and goals. It is *not* my objective to dictate to you what you need to do—it is only to help each county over the hurdles that will inevitably emerge. Montgomery County has been addressing this issue of domestic/family violence since 1978. We have accomplished much, but we still have far to go to meet our community's needs. No one has all the answers. It is only through collaboration and networking with each other that we will be able to *break the cycle of violence.*

MARCIA R. WOLF, PH.D.
Chairperson, Alliance Committee on
Domestic Violence ■

MARYLAND

The Alliance always welcomes new members.

Alliance members support the physicians and are recognized for their contributions to health, education, and the promotion of quality health care in Maryland.

For information on becoming a member, call JoAnn Troisi at Med Chi's Alliance office.
539-0872 (Baltimore area)
1-800-492-1056 (toll free in MD)



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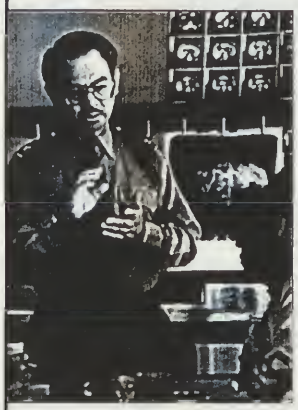


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Miscellaneous meetings

The biannual gastroenterology board review course, sponsored by the George Washington University Medical Center, at the Grand Hyatt, Washington, DC. Fee and credits TBA. — **Oct. 7–11**

Medical oncology board review course, sponsored by the George Washington University Medical Center, at the Ritz-Carlton Pentagon City, Arlington, VA. Fee and credits TBA. — **Oct. 8–12**

Cardiovascular services in a managed care environment, sponsored by the American College of Cardiology at the Hyatt Regency, Bethesda, MD. 6 Cat 1 AMA credits. Info: 1-800-257-4739. — **Oct. 10**

Integration of behavioral and relaxation approaches into the treatment of chronic pain and insomnia, sponsored by the NIH Office of Alternative Medicine and the NIH Office of Medical Applications of Research at the Natcher Conference Center, National Institutes of Health, Bethesda, MD. 14 Cat 1 AMA credits. Info: Laura Hazen, 301-770-0610. — **Oct. 16–18**

New techniques and concepts in cardiology, sponsored by the American College of Cardiology, Washington, DC. 16.5 Cat 1 AMA credits available. Info: 800-257-4739. — **Oct. 19–21**

Mental health of women throughout the life span conference, at Sheppard Pratt Conference Center, Baltimore, MD. 6 Cat 1 AMA/PRA credits. Fee: TBA. Info: 410-938-4598. — **Oct. 21**

Palliative care and the hospice concept, at GBMC, Baltimore, MD. 4 Cat 1 AMA credits. Fee: $50/physicians; $25/residents. Info: Ann Harris, 410-828-3670. — **Oct. 28**

Care of the asthmatic patient: a multidisciplinary approach, at GBMC, Baltimore, MD. 7 Cat 1 AMA credits. Fee: $40/physicians, residents. Info: Ann Harris, 410-282-3670. — **Nov. 1**

Pediatric ophthalmology: an update for pediatricians and family practitioners, at the GBMC Conference Center, Baltimore, MD. 4 Cat 1 AMA credits. Info: Ann Harris, 410-828-3670. — **Nov. 4**

St. Joseph Medical Center annual symposium: the interface of medicine and psychiatry, at the Noppenberger Auditorium of St. Joseph Medical Center, Towson, MD. 6 Cat 1 AMA/PRA/AAFP credits. Fee: $45/physicians, psychologists; $25/house staff, nurses, allied health professionals. Registration deadline: Oct. 27. Info: Pat Fuchsluger at 410-337-1501. — **Nov. 4**

Oncology issues for primary care physicians, sponsored by the Maryland Academy of Family Physicians at the Columbia Inn, Columbia, MD. 6.75 Cat 1 AMA/AAFP credits. Fee: $55/members; $75/nonmembers; $35/allied health professionals. No fee for inactive/life members/residents/medical students. Info: Maria E. Delgado, M.D., 410-747-1980. — **Nov. 11**

Topics in clinical rheumatology: the Mary Betty Stevens, M.D., arthritis update for family practitioners, internists, orthopedists, rheumatologists and other primary care providers, sponsored by the Arthritis Foundation, Maryland Chapter, at the Sheraton Baltimore North, Towson, MD. Fee: $50. Info: J. Karen Krug, 410-602-0160. — **Nov. 14**

Twelfth annual clinical update in pulmonary medicine CME course and luncheon, at the Trump Regency Hotel, Atlantic City, NJ, sponsored by the department of pulmonary medicine, Deborah Heart and Lung Center. CME TBA. Info: 201-385-8080. — **Nov. 19**

Williamsburg conference on heart disease, sponsored by the American College of Cardiology, in Williamsburg, VA. 18.5 Cat 1 AMA credits. Info: 800-257-4739. — **Dec. 3–9**

Miscellaneous meetings (continued)

Modern approaches to office emergencies, sponsored by the Maryland Academy of Family Physicians at the Annapolis Waterfront Hotel, Annapolis, MD. 10 Cat 1 AMA/AAFP credits. Fee: $115/members; $150/nonmembers; $65/allied health professionals. No fee for inactive/life members/residents/medical students. Info: Maria E. Delgado, M.D., 410-747-1980. — **Feb. 3–4**

Continuously throughout the year

American College of Cardiology, The Heart House Learning Center, Bethesda, MD. Info: 1-800-257-4737.

Management of cardiac arrhythmias in daily practice.	**Oct. 16–18**
Contemporary nuclear cardiology: entering the 21st century.	**Oct. 19–21**
Cases in echocardiography: TEE, Doppler and stress interpretation and clinical decision making for the advanced echocardiographer.	**Oct. 26–28**
Cardiac auscultation for physician assistants, nurse practitioners and cardiac nurses.	**Nov. 29–Dec. 1**
Advanced echocardiography: case studies and concepts.	**Dec. 11–13**
Problem solving in interventional cardiology.	**Jan. 8–10**
Interventional echocardiography: transesophageal, exercise, pharmacologic and intravascular—emphasizing case studies.	**Jan. 18–20**
Congenital heart disease in adolescents and adults.	**Jan. 22–24**

Fluorescein angiography conference, sponsored by the Retina Center, Saint Joseph Hospital, Baltimore, MD, first and-third Mondays of each month; 8:00–9:00 am. Fee: none. Info: R. Classon, 410-337-4500.

Sinai Hospital of Baltimore medical grand rounds, Zamoiski Auditorium, Thursdays, 9:00 - 10:00 a.m. Info: 410-578-5528.

Adult immunization	**Oct. 5**
Chronic fatigue syndrome: fact or fiction	**Oct. 12**
Glaucoma: facts and fancies	**Oct. 19**
Leukotrienes in asthma	**Oct. 26**
Treating seizures in the decade of the brain	**Nov. 2**
Diabetic retinopathy	**Nov. 9**
AIDS: the state of the syndrome	**Nov. 16**
Acute myocardial infarction	**Nov. 30**
The renin-angiotensin system	**Dec. 7**
Community-acquired pneumonias	**Dec. 14**
Medical interviewing and the doctor-patient relationship in the managed care era	**Dec. 21**

St. Joseph Medical Center's Minimally Invasive Training Institute. Surgical training seminars in Towson, MD. Seminar fees: $750/spine; $600/others. Course fees: $2,250/spine; $600/others. Info: Colleen Galloway, 410-337-4843.

Miscellaneous meetings (continued)

General Surgery

FDEL (formal diagnostic exploratory laparoscopy & technology seminar, colon, gastric, hernia) 8 Cat 1 AMA credits. **Oct. 10**

Laparoscopic colon resection course, 4 Cat 1 AMA credits. **Oct. 14**

Technology program (colon, gastric, hernia), 8 Cat 1 AMA credits. **Nov. 3**

Laparoscopic gastric surgery course, 6 Cat 1 AMA credits. **Nov. 4**

Laparoscopic gastric seminar, 6 Cat 1 AMA credits. **Nov. 8**

Laparoscopic hernia seminar, 6 Cat 1 AMA credits. **Nov. 20**

Gynecologic procedures

Lap-assisted vaginal hysterectomy & laparoscopic supracervical hysterectomy seminar, 8 Cat 1 AMA credits. **Oct. 31**

Hysteroscopy course, 8 Cat 1 AMA credits. **Dec. 1**

Laparoscopic bladder neck suspension course (BURCH procedure), 8 Cat 1 AMA credits. **Dec. 2**

Orthopedic surgery

Endoscopic spinal surgery course, 16 Cat 1 AMA credits. **Nov. 10–11**

Laparoscopic or thoracoscopic spinal seminar, 7 Cat 1 AMA credits. **Dec. 4**

The Johns Hopkins Medical Institutions

All courses at the Thomas B. Turner Building unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Medical Education, 720 Rutland Ave., Baltimore, MD 21205 (410-955-2959).

11th Birth conference: innovations in perinatal care, assessing benefits and risks, at the Hyatt Regency Baltimore Hotel, Baltimore, MD. Up to 13 Cat 1 AMA credits available. Fee: $300/physicians; $215/allied health professionals. **Oct. 7–8**

21st Annual topics in gastroenterology and liver disease, up to 24 Cat 1 AMA credits available. Fee: $525/physicians; $275/residents and fellows. **Oct. 11–13**

The second hands-on flexible sigmoidoscopy course, 7 Cat 1 AMA credits. Fee: $550/physicians; $400/residents, fellows. **Oct. 14**

37th Annual Emil Novak memorial course: gynecology, gynecological pathology, endocrinology and high-risk obstetrics, and Second annual Richard W. Telinde lecture, at the Stouffer Renaissance Harborplace Hotel, Baltimore, MD. Up to 55.5 Cat 1 AMA credits available. **Oct. 14–19**

The second prevention of coronary heart disease, at the Sheraton Baltimore North Hotel, Baltimore, MD. Up to 8 Cat 1 AMA credits available. Fee: $175/physicians; $130/residents, fellows, allied health professionals. **Oct. 18**

Comprehensive management of salivary gland neoplasms, up to 10 Cat 1 AMA credits available. **Oct. 26–27**

The Johns Hopkins Medical Institutions (continued)

Progress in pediatrics, 11 Cat 1 AMA credits. Fee: $150/physicians; $80/residents, fellows, nurse practitioners. — **Nov. 3–4**

Second international symposium on medical robotics and computer-assisted surgery, at the Marriott Inner Harbor Hotel in Baltimore, MD. 24 Cat 1 AMA credits. — **Nov. 4–7**

Advanced pediatric life support, 20 Cat 1 AMA credits. — **Nov. 13–15, June 10–12**

Topics in ambulatory medicine VII, at the Stouffer Renaissance Harborplace Hotel, Baltimore, MD. 18 Cat 1 AMA/AAFP credits. Fee: $500/physicians; $300/residents, fellows, allied health professionals. — **Nov. 15-17**

Diabetic retinopathy and venous occlusive disease, 8 Cat 1 AMA credits. — **Nov. 17**

Innovations in uveitis and ocular infections, 8 Cat 1 AMA credits. — **Nov. 18**

Impact of changing regulations on clinical trials, 15 Cat 1 AMA credits. — **Nov. 29–30**

Sixth annual neurology for the primary practitioner, at the Harbor Court Hotel, Baltimore, MD. 6 Cat 1 AMA credits. Fee: $135/physicians; $85/residents, fellows, allied health professionals. — **Dec. 2**

Eighth annual Wilmer Institute current concepts in ophthalmology, 20 Cat 1 AMA credits. — **Dec. 7–9**

11th Annual frontiers in research and clinical management of asthma and allergy, at the Asthma & Allergy Center, John Hopkins Bayview Campus, Baltimore, MD. 15 Cat 1 AMA credits. — **Jan. 19–21**

23rd Annual geriatrics symposium: a board review, at the Stouffer Renaissance Harborplace Hotel, Baltimore, MD. 30 Cat 1 AMA credits. — **Jan. 24–27**

Basic endoscopic sinus surgery, Cat 1 AMA credits pending. Fee: $895/labs and lectures; $350/lectures only. — **Jan. 25**

Advanced endoscopic sinus surgery, Cat 1 AMA credits pending. Fee: $1495/labs and lectures; $550/lectures only. — **Jan. 26–27**

13th Annual Houston Everett memorial course in urogynecology, 17 Cat 1 AMA credits. — **Feb. 23–24**

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Visiting preceptorship in pediatric critical care medicine. Ongoing five-day preceptorship by appointment. 40 Cat 1 AMA/PRA credits. $600.

The department of radiology and radiological sciences offers several courses in abdominal and obstetrical ultrasound. Info: P. Williams, 410-955-3169.

Visiting physicians. Offered throughout the year for experience in the lab and participation in read-in sessions; by appointment only. 40 Cat 1 AMA/PRA credits. $500.

Johns Hopkins medical grand rounds. Accredited audiovisual continuing education series of case discussions for clinicians; 30 topics per year in five bimonthly programs. Individual and group subscriptions. 40 Cat 1 AMA/PRA credits. Info: 410-955-3988.

Johns Hopkins sports medicine grand rounds. Accredited continuing education series of case discussions by a different presenter on the first Thursday of each month. Info: Carol Kelly, 410-383-0600.

Univeristy of Maryland School of Medicine

For each course, additional information may be obtained by contacting the Program of Continuing Education, University of Maryland School of Medicine, Room 14-011, BRB, 655 W. Baltimore St., Baltimore, MD 21201 (410-706-3956) or by calling the phone number listed after a specific program. FAX 410-706-3103.

7th Annual Maryland conference—AIDS: a challenge to primary care: science, practice, art, at the Baltimore Convention Center, Baltimore, MD. 9 Cat 1 AMA credits. Fee: $240. Info: Sylvia Scherr, 410-328-5759. **Oct. 5–7**

Treatment in epilepsy/Epilepsy Association of Maryland, at the Holiday Inn, Frederick, MD. 5 Cat 1 AMA credits. Fee: $50. Info: Cathy Bowers, 410-828-7700. **Nov. 3**

Endocrinology and metabolism update for the practicing physician—1995, at the Pier 5 Clarion Inn, Baltimore, MD. 10 Cat 1 AMA credits. Fee: $185. Info: John Wilber, M.D., Connie Ball, 410-328-2515. **Nov. 3–4**

Cyrus L. Blanchard and Bernard S. Kleiman lectures on head and neck trauma, at the University of Maryland Medical School teaching facility, Baltimore, MD. 8 Cat 1 AMA credits. Fee: $100. Info: Charles M. Suter, Ph.D. **Nov. 10–11**

Pollin Fellowship conference: crisis counseling for patients and families with chronic medical illnesses, at the Radisson Lord Baltimore, Baltimore, MD. 6 Cat 1 AMA credits. Fee: $45. Info: Vertell Porter-Brown, 410-328-6735, or Sharon M. Stenhouse, 410-706-3958. **Nov. 17**

Surgical dilemmas in glaucoma management, at the Sheraton Inner Harbor Hotel, Baltimore, MD. 7 Cat 1 AMA credits. **Feb. 23**

PHYSICIAN'S RECOGNITION AWARD

During August 1995, the physicians listed below received the American Medical Association (AMA) Physician's Recognition Award. Established in 1968, the award's purpose is to encourage physician participation in continuing medical education and to recognize those physicians who have voluntarily completed programs of continuing medical education.

Necati M. Alp, M.D.
William S. Bremer, M.D.
Gerald S. Brown, M.D.
Robert J. Dawson, M.D.
John N. Diaconis, M.D.
Jack R. Epstein, M.D.
Bernard J. Ficarra, M.D.
Max C. Frank, M.D.
Linda L. George, M.D.
John A. Gschwend, M.D.
Rafi Q. Iqbal, M.D.
M. Zuhdi Jasser, M.D.
Robert S. Knight, M.D.
Edward W. Lampton, M.D.
Sunil K. Nachnani, M.D.
Nasser Rezai, M.D.
Elizabeth A. Schlenoff, M.D.
Brian K. Zell, M.D.

University of Maryland School of Medicine (continued)

Self-Directed CME Activities

Optimal dosing in chemotherapy: adoptive control with carboplatin, video tape, monograph and test. Expires March 1996, 3 Cat 1 AMA credits. Info: 212-924-3044.

U.S. medical costs and values: primary prevention versus end-stage treatment, monograph and test. Expires Aug. 1996, 2 Cat 2 AMA credits. Info: 908-281-3772.

Lipid management for coronary heart disease: a proven hypothesis, audio tape and test. Expires Aug. 1996. 1 Cat 2 AMA credit. Info: 609-497-9743.

Drug-drug interaction: focus on antidepressants, monograph w/response test. Expires Aug. 30, 1996. 2 Cat 1 AMA credits. Info: 203-629-2555.

Continuously throughout the year

Academic rounds and conference, each academic department within the school of medicine has a series of lectures and/or seminars available to physicians. Cat 1 AMA credits available. Info: 410-706-3956.

The Uniformed Services University of the Health Sciences in Bethesda, Maryland, has been resurveyed by the Accreditation Council for Continuing Medical Education and awarded accreditation for six years as a sponsor of continuing medical education for physicians.

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Changes in the Prevalence and Costs of Cigarette Smoking and Smoking-Attributable Deaths, Maryland, 1987-93

October 1995

Since the first Surgeon General's report to America about the dangers of cigarette smoking, the public health community has worked to reduce these ill effects.[1] Cigarette smoking contributes to the cause of many chronic conditions, some of which include the ten leading causes of death - heart disease, cancer, stroke, COPD, and influenza.

A recent report of the incidence of cancer in Maryland shows smoking as a factor in 41% of the new cases of cancer in Maryland.[2] Evidence indicates that smoking may be an initiator of cancer in other sites not previously suspect.[3] The latest report from the National Cancer Institute shows Maryland to have statistically higher cancer mortality rates than the nation and fourth worse among the states and the District of Columbia.[4] Due largely to other states' increasing rates of lung cancer, Maryland's rank shifted from second (1983-87) to fourth (1987-91).[4,5]

In response to the high cancer rate, in combination with the need for an extensive strategy to prevent cancer, the Maryland

Figure 1

Direct & Indirect Health Care Costs
Maryland, 1987 - 1993
Health Care, Morbidity and Mortality Costs
(Costs in Billions)

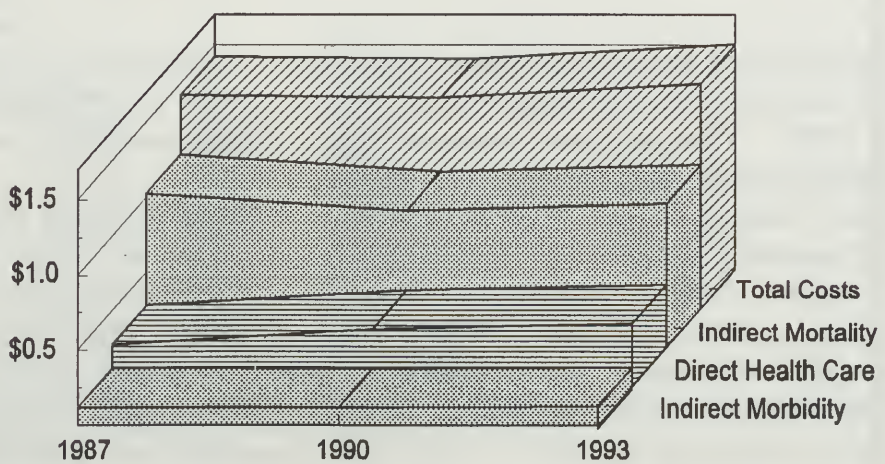


Table 1

Substance Use in the Last 30 Days Among 6th - 12th Graders Maryland 1988-89, 1990 & 1992

Substance Used	Grade	1988-9 %	1990 %	1992 %
CIGARETTES	6th	3.60	2.90	4.70
	8th	11.30	12.90	14.40
	10th	19.00	22.70	22.70
	12th	24.10	27.30	31.50
SMOKELESS TOBACCO	6th	0.60	1.70	2.30
	8th	1.90	3.50	3.00
	10th	3.70	6.30	5.60
	12th	3.90	7.70	8.10
ALCOHOL	6th	9.50	9.00	11.80
	8th	27.20	27.60	26.20
	10th	50.50	43.90	40.80
	12th	60.20	52.80	52.90
NARCOTICS (other than heroin)	6th	2.30	1.40	2.50
	8th	4.70	2.30	1.90
	10th	6.90	4.00	3.60
	12th	6.30	3.70	3.50

Source: 1992 Maryland Adolescent Drug Survey, MD Department of Education

Department of Health and Mental Hygiene developed the Maryland Cancer Control Plan in 1990.[6] This plan was developed with funding from the National Cancer Institute and with a consensus that there are effective interventions that address cancer mortality in our state. The plan identifies the following priority intervention areas: tobacco use prevention and cancer screening activities, broadening the use of mammography to detect breast cancer early in women 50 and older, and bolstering the regular use of Pap Smears among women who lack of access to care. Areas addressed in less detail included the role of nutrition, access to state-of-the-art treatment, and effects emanating from the environment as primary cancer prevention methods.

METHODS

Since 1986, the Department of Health and Mental Hygiene (DHMH) has monitored smoking, its effects and costs annually as part of the Maryland Behavioral Risk Factor Survey (BRFS). The BRFS is a telephone survey of health behavior among Maryland adults.

The Maryland Department of Education (MSDE) tracks teen smoking in its biannual survey of students in grades 6, 8, 10, and 12. Tobacco and other drug use results are available for 1990 and 1992.[7] The 1994-95 school year survey will be released in the Summer of 1995. The DHMH Alcohol and Drug Abuse Administration collected information for the 1988-89 school year.[8]

The Maryland Center for Health Statistics compiled death information. Smoking attributable deaths and costs were calculated using SAMMEC, version 2.1, a CDC developed software. The Health Care Financing Administration (HCFA) supplied health care expenditures for 1990. The costs

Table 2

Smoking Prevalence Among Maryland Adults, 1986 - 1994

(%)	1986	1987	1988	1989	1990	1991	1992	1993	1994
White Males	27.6	24.2	25.2	24.9	23.7	26.4	20.8	20.2	21.1
White Females	28.6	27.7	23.0	22.7	22.5	19.8	21.2	20.0	20.0
Non-white Males	36.1	24.6	25.7	19.0	29.6	26.1	20.6	22.8	22.0
Non-white Females	25.7	18.6	30.8	20.0	17.8	17.2	18.0	15.4	16.6
Total	28.7	24.8	25.1	22.8	23.1	22.6	20.9	19.7	20.1

Sources: Maryland Behavioral Risk Factor and Nutrition Survey, 1986, Maryland Behavioral Risk Factor Survey, 1987-1994

were adjusted to 1993 for inflation and expansion of health care costs.

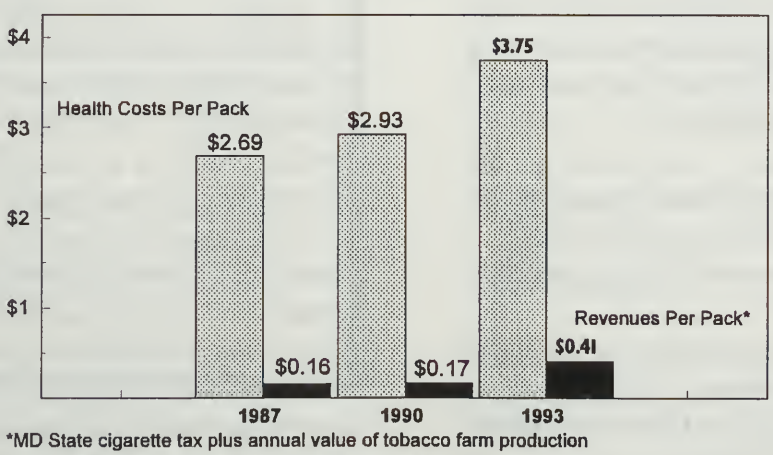
RESULTS

Maryland Adolescent Drug Survey

In the 1992 school survey, 18% of the 6th graders and 60% of 12th graders reported having ever smoked. Measuring current smoking, 5% of 6th graders and 32% of 12th graders surveyed smoked in the past 30 days (see Table 1). Smoking prevalence among Maryland 6-12th graders increased between 1988 and 1992. While rates for other drugs, like alcohol, steroids, crack, nitrates and narcotics other than heroin declined among seniors, smoking did not. Smokeless tobacco use has increased 50 - 280% since 1988-89 (see Table 1). When compared to students in a national study, a greater percentage of Maryland students reported using cigarettes

Figure 2

Direct & Indirect Health Care Costs of Smoking and Revenues Per Pack
Maryland, 1987 - 1993



*MD State cigarette tax plus annual value of tobacco farm production

Source: Maryland Comptroller of the Treasury, SAMMEC

Table 4

The Costs of Smoking in Maryland 1987 to 1993

	1987	1990	1993
COSTS			
Direct Health Care	$277,178,135	$379,441,663	$418,844,377
Indirect Morbidity (Illness)	$119,801,507	$118,261,862	$126,149,537
Indirect Mortality	$1,023,754,040	$908,800,346	$956,621,604
Total	$1,420,733,682	$1,406,503,871	$1,501,615,518
COSTS PER CAPITA			
Direct Health Care	$136	$171	$176
Indirect Morbidity (Illness)	$59	$53	$53
Indirect Mortality	$453	$383	$367
Total	$648	$607	$596
YEARS OF POTENTIAL LIFE LOST	99,467	88,699	89,718
Males	62,310	54,917	53,742
Females	37,157	33,782	35,975

Source: SAMMEC analysis.

than their counterparts in other states.[7]

Though boys begin smoking earlier, girls, catch up by initiating smoking throughout high school. As high school seniors, boys and girls have similar rates of smoking.

Maryland Behavioral Risk Factor Survey and Smoking-Attributable Mortality, Morbidity, & Economic Costs Analysis

Among adults, however, smoking has declined steadily. Smoking among adults has gone from 29% (1986) to 20% (1994) since BRFS tracking began (see Table 2).

The SAMMEC analysis revealed 6,715 smoking-attributable deaths in 1993 (17% of all deaths). The number of smoking-attributable deaths includes an increase in lung cancer deaths among women. Of all Maryland cancer deaths, 28.5% were attributable to smoking -- making smoking the leading cause of preventable cancer deaths.

From 1987 to 1993 deaths due to smoking increased by 188, although the proportion of persons who die because of smoking remained constant during this five-year period. Changes in population and smoking initiation over time account for this small increase. Nearly two-

SAMMEC GLOSSARY

Direct Health-Care Costs - Costs for the prevention and detection of smoking-related diseases and injuries, and for the treatment and rehabilitation of smokers. Direct costs are typically categorized into primary cost centers; hospitalization, physicians' services, medication costs, nursing home costs, and other professional services. SAMMEC 2.1 software estimates these costs by using smoking attributable fractions (SAFs) for annual hospital days and annual physician visits applied to estimated state-level health care costs for the treatment of persons with neoplasms, cardiovascular, and respiratory diseases.

Indirect Mortality Costs - Indirect mortality costs are calculated as the foregone wages and salaries of persons who die prematurely from smoking-related causes. The estimate of forfeited lifetime earnings is the present value of future earnings. User-supplied mortality data are incorporated into the calculation.

Indirect Morbidity Costs - Indirect morbidity costs are the costs of lost earnings and productivity for persons disabled by smoking-related chronic diseases. SAMMEC 2.1 software estimates these costs by using SAFs for work-loss day and bed disability days applied to estimated state-level earnings, and it includes value for housekeeping services.

Total Costs - Total Costs are the sum of direct health care costs, indirect mortality costs, and indirect morbidity costs. These estimates are presented by sex for ages 35 to 65 or over.

Smoking-Attributable Fraction (SAF) - The SAF is the maximal proportion of disease cases or deaths causally linked to cigarette smoking.

thirds of the smoking related deaths took place among men.

SAMMEC estimates the total direct health care costs to be about 1.5 billion dollars per year (see Table 4). Direct medical care costs increased monotonically between 1987 and 1993 and exceeded the drop in indirect mortality costs (see Figure 1). Total costs during this period form a U-shaped curve, suggesting that increases in medical care costs have surpassed any gains made through the decline in smoking during the seven-year period.

Consequently, per pack health care costs are escalating. The portion of these direct and indirect costs recouped in cigarette tax or farm revenues amounts to about 11% (41 cents for every $3.75 of health costs, see Figure 2). Note, however, SAMMEC does not include costs for caring for burn deaths, ETS, prenatal conditions caused by maternal smoking, and other smoking attributable diseases.

Cigarette smoking exacts another cost from children. Environmental tobacco smoke prevails as the primary cause of the estimated 66 smoking-attributable deaths among persons under age 20 in 1993. Forty-three of those deaths occurred among infants (under one year).

This accounts for 6% of all deaths to children under age one and 5% of children 1-17. SAMMEC attributed 19 to low birth weight, 10 to Sudden Infant Death Syndrome, and 14 to various respiratory problems. This makes cigarettes the third leading cause of death among infants after "conditions originating in the perinatal period" and congenital anomalies.

CONCLUSION

While adults had quit smoking in quantifiable amounts through 1988, declines have since stagnated. The last drop in smoking resulted from a cigarette tax hike. "Price elasticity" did

not predict who did quit with this increase in price.[9] It appears, however, that persons having more "future benefits" did quit when provided a societal cue. The percentage of adult Marylanders smoking has not changed since then.

Among adults in the United States who have ever smoked daily, 91.3% tried their first cigarette and 77.0% became daily smokers before the age of 20 years.[10] Growing youth smoking prevalence will undoubtedly lead to a larger pool of adult smokers. Without intervention, Maryland should expect even greater smoking-attributable death, disease and costs in the future.

Maryland Occupational Safety and Health enacted workplace regulations that eliminate secondhand smoke from most enclosed workplaces.[11] Most adults and adolescents in the workforce will be protected from ETS as a result. The BRFS will track any changes in smoking behavior among adults that may result from this effort to protect worker safety.

The community at large must be involved in planning interventions to reduce unnecessary smoking-attributable illness, disability, and death. Such interventions must also include policy efforts to reduce youth access to tobacco; allow localities to pass stronger tobacco use prevention laws than the state; curb tobacco advertising targeted at children and adolescents; and provide for continued treatment programs for smokers who wish to quit.

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1 U.S. Department of Health and Human Services. Smoking & Health: Report of the Advisory Committee to the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Public Health Service, 1994.

2 Maryland Cancer Registry. Final Maryland Cancer Registry Data Report Maryland Statewide, 1992. Bel Air, MD 1995.

3 Boutron M, Faivre J, et al. Tobacco, Alcohol, and Colorectal Tumors: A Multistep Process. AJE 1995: 141 (2).

4 American Cancer Society. Cancer Facts & Figures 1995. 95-375M-No. 5008.95.

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10 US Department of Health and Human Services. Preventing Tobacco Use among Young People: a Report of the Surgeon General. Atlanta: US Department of Health and Human Services, Public Health Service, CDC, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1994.

11 Maryland Register, Vol 21, Issue 15. Friday, July 22, 1994.

Prepared by N. F. Kanarek, PhD, Megan Pulliam, and Alyse Weinstein of the Office of Planning, Evaluation, and Program Development and Glenn E. Schneider, MPH, of the Office of Health Promotion, Education and Tobacco Use Prevention in the Local and Family Health Administration.

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In a case-control study (*BMJ* 1995;310:830–833) **involving 72 women aged under 45 with ischemic stroke and 173 randomly selected controls, ischemic stroke was strongly associated with migraine.** Risk of ischemic stroke was substantially increased for young women with migraine who used oral contraceptives or who smoked 20 or more cigarettes per day. Although the overall rate of stroke for young women with migraine is relatively low, investigators recommend that physicians reduce known risk factors for stroke among this population, particularly smoking and use of oral contraceptives.

A retrospective review of the cardiopulmonary resuscitation (CPR) records of 668 patients hospitalized in both intensive and nonintensive care units during a 3-year period supports previous findings that **the success rate for CPR is low.** Immediate survivors (respiration and blood pressure restored) included 140 of 360 ICU patients, 49 of 79 patients in a non-ICU telemetry unit, and 112 of 229 patients in a medical/surgical unit. However, in the first group, only 12 patients (3.3%) survived to discharge; in the second group, only 20 (25.3%); and in the third group, only 23 (10.0%). Those alive one year later included 9 ICU patients (2.5%), 17 non-ICU telemetry patients (21.5%), and 16 medical/surgical patients (7.8%). The authors conclude that wider recognition of the limitations of CPR would help patients make better informed choices in advance directives (*Arch Intern Med* 1995;155:1277–1280).

There have been conflicting data regarding the effect, if any, of influenza vaccine on prothrombin time among patients taking warfarin. **A study of 41 men aged 44 to 76 (mean, 65.7) receiving long-term warfarin therapy who were given 0.5 mL influenza vaccine intramuscularly indicates that influenza vaccine can be administered intramuscularly without the risk of local bleeding complications.** In the study, there was no statistically significant change in prothrombin time between baseline and days 3, 7, and 14 after vaccination, no significant change in arm circumference, no clinically detectable local complications, and no episodes of major or minor bleeding (*Arch Intern Med* 1995;155:1529–1531).

Results of a small unblinded trial of methylphenidate (Ritalin) for nicotine withdrawal suggest that it may be a useful adjunct in smoking cessation. Nineteen smokers with self-reported histories of nicotine withdrawal symptoms during prior quit attempts received methylphenidate 30 mg target daily dosage for 5 days following abrupt smoking cessation. Of these, 12 (71%) rated withdrawal relief "very definite," 13 (76%) rated the quit attempt "much easier than other times," and 12 (63%) were confirmed abstinent at day 5. Although there was a high relapse rate (only 11% were abstinent at 3-month follow-up), study investigators conclude their findings warrant further investigation in longer-term, placebo-controlled trials (*Addict Behav* 1995;20:481–490).

Although several studies have shown that exposure to environmental tobacco smoke is associated with an increased frequency of respiratory illness in young children, most have assessed exposure through parental interviews. **In a study of 501 randomly selected children aged 1-5** attending an outpatient clinic in Greece (which has the highest tobacco consumption per capita in the European Union), **investigators measured urine levels of cotinine (the major metabolite of nicotine) to confirm exposure to environmental tobacco smoke.** After adjusting for potential confounding factors, it was determined that **exposed children were 3.5 times more likely to have increased respiratory morbidity** (*Lancet* 1995;346:280–281).

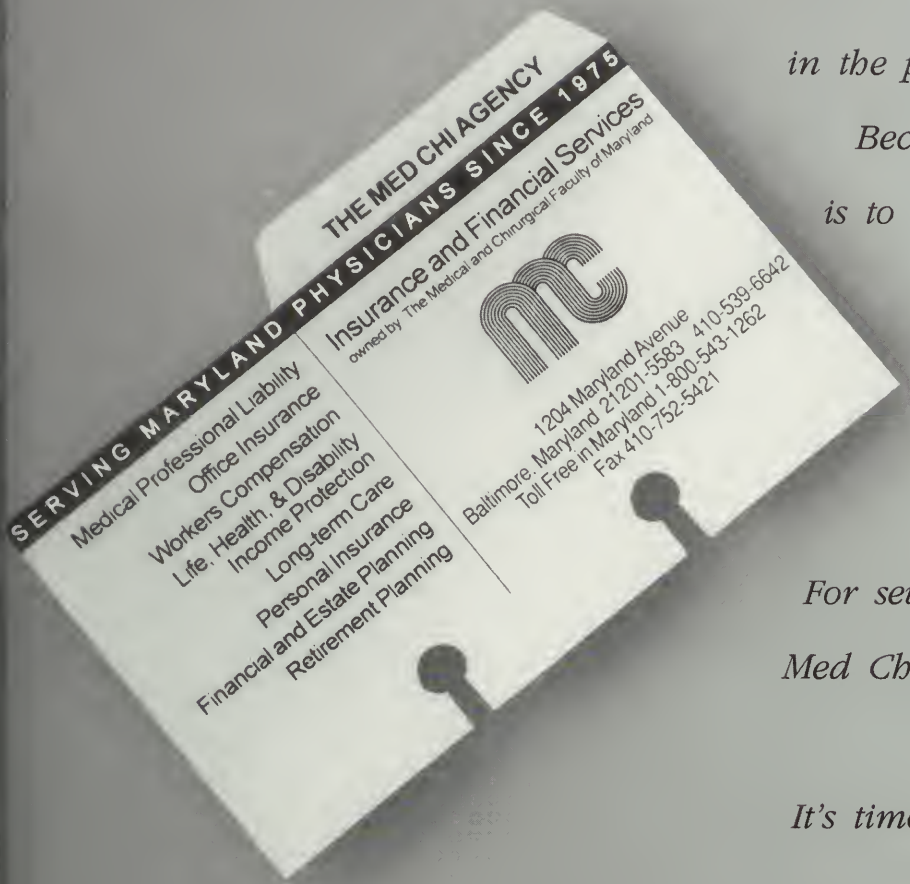
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Achalasia is a disorder of esophageal motility characterized clinically by severe difficulty swallowing food. The physiologic abnormality is failure of the lower esophageal sphincter muscle to relax after swallowing so that food can enter the stomach. Heretofore, treatment has involved either surgical cutting of the muscle or nonsurgical disruption of the sphincter by forceful inflation of a large balloon in the esophagus. Although either treatment generally results in significant improvement, balloon dilitation is associated with a significant incidence of esophageal perforation (3% to 10%) and surgery requires a considerable period of convalescence. Johns Hopkins Medical Center investigators report that injecting **botulinum toxin**—a potent inhibitor of the release of acetylcholine from nerve endings—into the smooth muscle of the lower esophageal sphincter **led to a 33% decrease in the pressure of the sphincter and marked symptomatic improvement in 19 of 21 patients with achalasia. Six months later, significant relief of clinical symptoms persisted in 14 of the 21 patients** (*N Engl J Med* 1995;322:774-778). Although longer term follow-up is needed, this novel therapy appears to offer a safe, simple alternative to the more dangerous and less predictable modalities currently available.

Serum transaminase levels putatively do not rise until 24 to 48 hours after a hepatotoxic acetaminophen overdose. **Results of a study from the Long Island Poison Control Center in New York, however, suggest that an early rise in serum aspartate aminotransferase (AST) does not preclude the possibility of acetaminophen overdose.** Investigators reviewed data from 19 patients who presented within 24 hours of acute acetaminophen overdose, had no history of hepatic disease, and had not ingested another hepatotoxin. Eleven patients had AST elevations within 24 hours of acetaminophen ingestion, and 4 had elevations within 8 hours (*Ann Emerg Med* 1995;2649-53).

Crohn disease is an often disabling condition characterized by severe ulceration in the small intestine and colon. Although the etiology remains uncertain, modification of intestinal cells so that the body's own defense mechanisms attack the intestine appears to be an important disease component. Standard treatment usually involves immunosuppression with drugs such as prednisone, 6-mercaptopurine, or cyclosporine. Researchers in Amsterdam, however, recently reported (*Gastroenterology* 1995;109:129-135) that **8 of 10 patients with unresponsive, active Crohn disease healed colonic ulcerations and showed marked clinical improvement in disease activity 4 weeks after treatment with a single injection of a monoclonal antitumor necrosis factor antibody.** Tumor necrosis factor (TNF), a potent proinflammatory cytokine, has been found in increased concentrations in intestinal mucosa and stools of patients with inflammatory bowel disease. Investigators hypothesized, apparently correctly, that neutralization of TNF would lessen the inflammation and damage to the intestinal lining seen in Crohn disease. Average duration of clinical improvement after a single dose of antibody was four months. The approach opens a whole new avenue of potential therapies for a recalcitrant, disabling disease; results of longer, controlled trials will be awaited with high anticipation.

British investigators report (*Lancet* 1995;345: 1604-1606) that the topical beta-blocker **timolol** (Timoptic), used to control intraocular pressure in patients with ocular hypertension or open-angle glaucoma, **may cause bronchospasm in elderly patients with no history of reversible airways disease.** The randomized, crossover study compared timolol, betaxolol (Betoptic, a cardioselective adrenergic receptor blocking agent), and dipivefrine (a prodrug metabolized to adrenalin) in 72 elderly patients aged 60 to 92. Although the authors acknowledge that timolol was better for controlling ocular hypertension than betaxolol or dipivefrine, they recommend that for elderly glaucoma patients, alternatives to beta-blockers be considered, particularly cardioselective agents.



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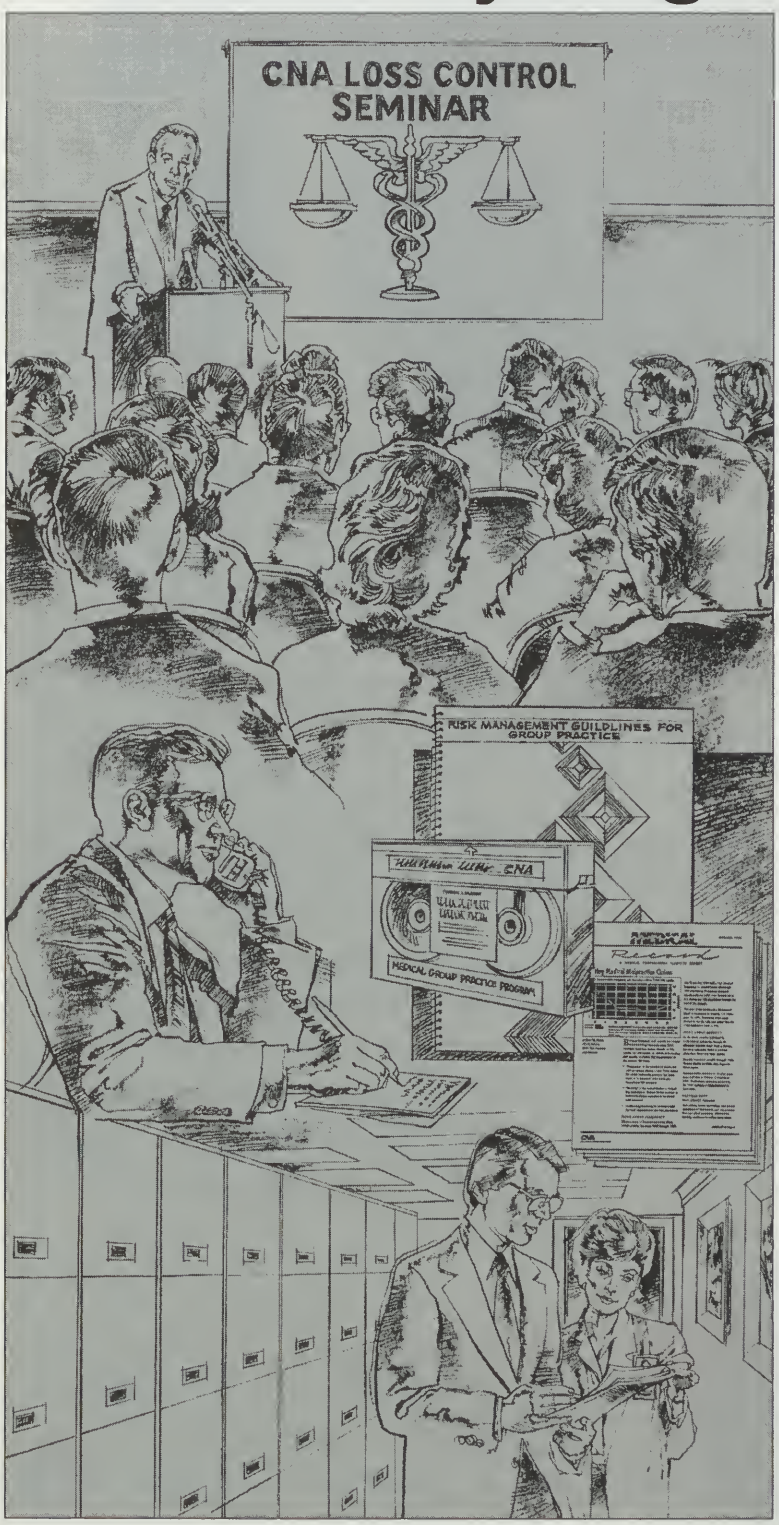
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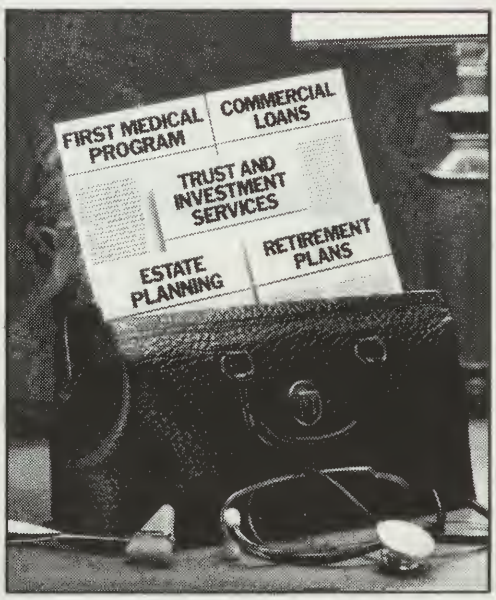
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Chief Executive Officer's Newsletter

November 1995

President's Eastern Regional Conference

The President's Eastern Regional Conference for physicians in Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester counties will be held

Thursday, November 16, 1995, at 6:00 p.m.
Cambridge Yacht Club, Cambridge, Maryland.

Registration begins at 5:45, and dinner will be served. Conference topics will include a legislative preview for 1996, an update on the 1115 Medicaid waiver, and an overview of transforming Medicare. For more information, or to register for this conference, please contact Joan Mannion at 410-539-0872 or 1-800-492-1056. Reservations must be received by **November 9, 1995**.

Med Chi Awarded Grant for Clinical Breast Examination Courses

The Maryland Department of Health and Mental Hygiene (DHMH) has awarded Med Chi a grant to develop and implement two courses for physicians: a small-group, clinical training course in performing the Mammacare method of clinical breast examination (CBE), and a self-taught tutorial in the Mammacare method of CBE. After developing the programs, Med Chi will provide them to primary care physicians throughout the state. Med Chi plans to start offering these programs in April 1996.

Med Chi Dues Billing

By now, all members should have received their first bill for 1996 membership dues. Med Chi provides its members with many benefits, including free CME programs, legislative representation, professional publications, and insurance products and financial services through the Med Chi Agency. Maintain your voice in organized medicine by renewing your Med Chi membership today. If you have not yet received your dues bill, or have any questions about the bill, please call Wanda Griebel in Med Chi's membership services, 410-539-0872 or 1-800-492-1056.

AMA Endorses House GOP Plan To Transform Medicare

The American Medical Association supports the House Republican plan to transform Medicare. According to Lonnie R. Bristow, AMA president, "The legislation will expand choices for Medicare beneficiaries...."

Other key reforms in the House leadership package supported by the AMA are:

- Protection for patients dealing with managed care plans, and guarantees that patients be informed about their rights and responsibilities.
- Changes in antitrust policies to facilitate physician-sponsored organizations and self-regulatory activities.
- Reform of medical liability laws.
- Meaningful regulatory relief by changing Stark I and II "self referral" rules, and rationalizing CLIA. Creation of a trust fund to continue federal support for medical training.
- Avoidance of precipitous payment rollbacks that could adversely affect access to care.

AMA Managed Care Information Gathering

The AMA Private Sector Advocacy Team is gathering information about gag rules in managed care contracts that interfere with a physician's ability to communicate with a patient. If you have any information about, or examples of, such a provision, please contact either Carol O'Brien, J.D., (312-464-4367) or Helen Jameson, J.D., (312-464-4271).

American Cancer Society Offers FreshStart Smoking Cessation Program

In conjunction with the Great American Smokeout week (November 13-17), the American Cancer Society (ACS) will initiate a new smoking cessation program called FreshStart. FreshStart classes will be offered throughout the state free of charge immediately after Smokeout Week. Doctors can refer their patients to the Maryland headquarters of the American Cancer Society (410-931-6850), and ACS will assist these patients in registering for a FreshStart program. For more information, call the American Cancer Society at 410-931-6850.

Medicaid Management Information System

DHMH has been working for the past two years on implementing a new Medicaid Management Information System (MMIS-II). The implementation date for this new system was scheduled for October 1995; however, due to concerns expressed by the provider community, the implementation date has been extended to December 4, 1995. The first payment run under the new system will be on December 6, 1995. The following implementation schedule applies to medical assistance providers other than pharmacy providers submitting through point of sale.

November 10, 1995, is the last day for paper claims to come into mail room using either the five-digit provider number or the old state forms (Vision-Form 246; Dental-Form 234; Long Term Care-Form 263; or Home Health Report and Invoice-Form 248 renamed Community Based Services Invoice in the new system). Providers should continue to use the HCFA-1500 and UB92. There will be **no** replacements for these two billing forms. However, other required changes must be made, e.g., nine-digit provider number.

November 13, 1995–Medical Assistance will only accept claims received with new provider numbers and other requested changes on new forms where applicable.

November 28, 1995–Every tape and dial-up claim using current format and provider number must be received prior to **2:00 p.m.** Claims submitted electronically after **2:00 p.m.** must be in new format. For tape and dial-up billers, the adjudication file output from the payment run of November 29, 1995, will be in the current format. Claims remaining on the system on November 28, 1995, will be automatically rejected and will report on the voucher dated November 29, 1995.

December 6, 1995–First scheduled payment run under the new system for paper claims received on or after November 13, 1995, and dial-up or tape claims received after 2:00 p.m. on November 28, 1995.

December 8, 1995–For tape and dial-up billers, the adjudication file output from the payment run of December 6, 1995, will be in the new format.

Medicare Reimbursement for Colonoscopies

The Health Care Financing Administration (HCFA) has announced a new national policy for reporting incomplete or failed colonoscopies. The policy is effective for claims received on or after **November 1, 1995,** and provides for payment for the procedure that was actually performed. A failed colonoscopy (e.g., the inability to extend beyond the splenic flexure) must be billed as a sigmoidoscopy using procedure code 45330. Additional payment is allowed only when modifier 22 is reported and there is supporting documentation which indicates that significantly more time and effort was involved in the procedure than is required in a typical sigmoidoscopy. Site of service reduction would also apply when the failed colonoscopy is done in the hospital setting.

Angelo J. Troisi, F.A.C.H.E.
Chief Executive Officer



Medical
and Chirurgical Faculty
of Maryland

President's Letter

Prepared by the President of the Medical and Chirurgical Faculty of Maryland as a service to members

SUBJECT: STATUS OF MARYLAND PHYSICIANS, INC. EFFORTS TO DEVELOP A PHYSICIAN-OWNED NETWORK

Dear Colleague:

At a special meeting on October 11, 1995, the Board of Trustees discussed the status of the efforts of Maryland Physicians, Inc. (MPI) and reviewed legal issues pertaining to this matter.

It was presented in a legal analysis that the role of MPI as described in its letter of intent with First Option Health Plan (FOHP) raised some serious legal issues, i.e., that MPI was obligated to secure Med Chi's endorsement of FOHP and to assist in recruiting physician members. MPI also intended to receive as a fee, either a percentage of premiums, a lump sum fee, or both for "administrative services." We must ensure that neither MPI or Med Chi could be viewed as unlicensed securities brokers in conducting business with FOHP.

Further, because Med Chi is a nonprofit organization, its endorsement of a private effort to sell stock to Med Chi members might raise issues of private benefit and private inurement. Due to the securities issues, tax issues, and antitrust issues, counsel's report strongly recommended that MPI and Med Chi not engage in marketing efforts for FOHP until these issues have been thoroughly analyzed and adequate protection for MPI and Med Chi are built into the definitive agreement.

Based upon this report, and in consideration of the basic thrust of the House of Delegates adopted Resolution 20-95 in which it was accepted that MPI be directed to develop a physician-owned entity, the Board of Trustees without opposition adopted the following joint resolution submitted by the Baltimore County Medical Association and the Anne Arundel County Medical Society:

"Resolved, that the Board of Trustees instruct MPI to develop a physician-owned or controlled entity; and

Resolved, that the Board of Trustees direct MPI to consider other alternatives to First Option of New Jersey and more specifically, we suggest that the Board of MPI review and present other opportunities for development; and

Resolved, that the Board of Trustees review the various options available before MPI is committed on its current course; and

Resolved, that before either MPI or the Med Chi Board of Trustees finalizes approval of a relationship with, or creation of any entity to achieve the above, it must be formally presented at a special or regular House of Delegates meeting for discussion and approval."

In addition, and to add further clarity to this matter, a motion was introduced and adopted that:

"The Med Chi Board of Trustees is to instruct MPI to cease all discussions with FOHP. Due to legal issues raised, Med Chi cannot endorse any managed care organization at this time."

The passage of this resolution by the Board of Trustees provides direction to the MPI Board of Directors to develop a physician-owned or controlled entity, to seek alternatives to FOHP and to provide viable options to the House of Delegates for discussion and approval prior to taking definitive action in setting up or entering into a relationship with any entity. This is to be accomplished subject to legal review.

In the adoption of this motion by the Board, the MPI Board will not pursue any further involvement with FOHP, but will continue to seek appropriate relationships so as to meet the direction of the Board of Trustees and the House of Delegates which are in the best interest of the physician members of Med Chi.

Please be assured that I will continue to be assertive on your behalf exercising due diligence in this effort and will provide you with factual and legally reviewed information. I can do no less.

J. RICHARD LILLY, M.D.
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Growth Stock	★★★	★★★★	★★★	★★★
Mid-Cap Growth	★★★★★	★★★★★	–	–
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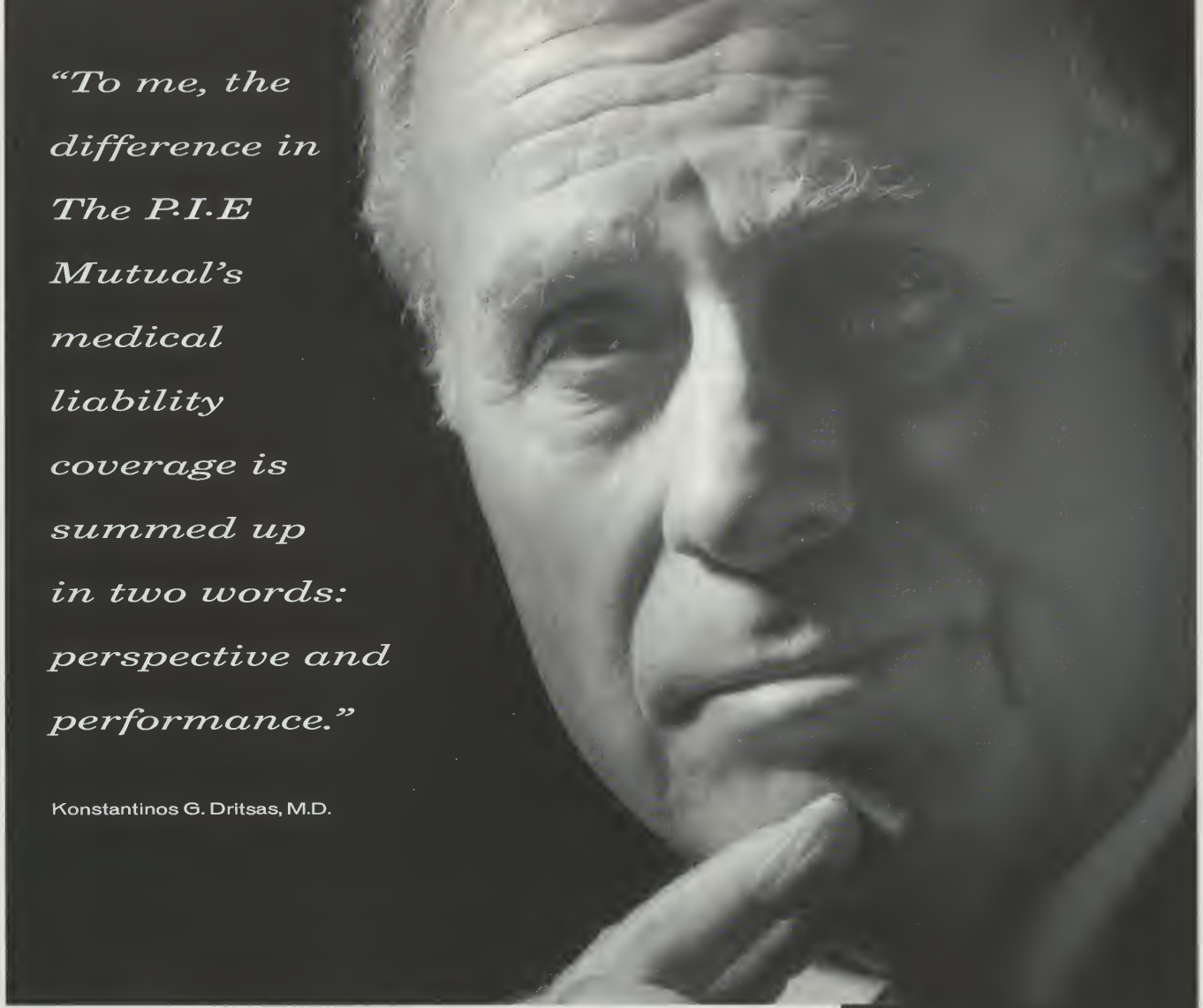
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Editors' Introduction

FIFTY YEARS AGO, WAR WAS the dominant theme throughout the world. World War II dramatically affected many people, both personally and professionally, and significantly changed the medical profession.

The war forced medical schools to accelerate their curricula so that needed physicians could be trained faster and enter the military. The war amplified the need for specialists, particularly surgeons and infectious disease specialists. Thousands of physicians joined the Medical Corps of the armed forces, even though they had no assurance that they would be assigned to duties that reflected their training. Physicians who remained in the United States had to fill the void left by those who were sent overseas--to the Pacific, Europe, India, Burma, and the Mediterranean.

Throughout the war, *The Journal of the American Medical Association* ran a weekly section entitled Medicine and War. It included news about canceled medical meetings, shortages of medical supplies and personnel, military and other government citations awarded to physicians, and the names of physicians killed in action.

In Maryland during 1940, the Johns Hopkins and University of Maryland medical schools were invited by the War Department through the Office of the Surgeon General to form provisional groups to function as the nuclei of army hospitals in the event of war. The invitation was immediately accepted by both groups and they were authorized to organize hospital units that would each care for 1,000 patients. The hospitals would be known as the 18th General Hospital (from Hopkins) and the 42nd General Hospital (from the University of Maryland), continuing the designations of the schools' World War I hospitals. Physicians, dentists, nurses, and other paramedical and support personnel were recruited. A few weeks before their activation, however, they were notified that experience had indicated that 500-bed hospitals were more appropriate and to alter their plans accordingly. The local units offered to split their existing staffs and to provide two 500-bed hospitals each. The Office of the Surgeon General not only quickly accepted the proposal, but made a similar offer to the other units around the country. The change required a rapid reshuffling of personnel to ensure that each unit would contain the proper number of various specialists. The two Hopkins hospitals would be known as the 18th & 118th; those from the University of Maryland as the 42nd & 142nd. When the Maryland units were finally activated on April 11, 1942, after some weeks of indoctrination in this country, they were ordered to the Pacific Theater.

This year, as the United States marks the 50th anniversary of V-E Day, and the victory over Japan, *The Maryland Medical Journal* has devoted this issue to Maryland physicians who were touched by the war. This issue is not, nor was it ever intended to be, a definitive work on the subject of medicine during WWII. Instead, it provides personal and professional insights on the war. What follows is a collection of brief histories on the four general hospitals formed by Hopkins and the University of Maryland, personal recollections, correspondences, and profiles of physicians, nurses, or enlisted men who served during the war.

Compiling and organizing this issue was a challenging, yet rewarding endeavor. While this issue recalls the activities of many of our colleagues, we recognize that we have not included everyone. Please be assured that any omission was unintentional, and necessitated by time and space constraints.

Many people contributed their time, effort, and enthusiasm to this issue, and we thank everyone of them. Special thanks go to Dr. Timothy Baker for the concept for this issue; to Drs. R. Carmichael Tilghman, Theodore E. Woodward, and George Yeager for their time; to Dr. Joseph Miller for encouraging a number of physicians to contribute to this issue; to Dr. Caroline Bedell Thomas for sharing her personal letters to her husband; and to all those who shared their personal experiences. We hope that you will enjoy reading this issue as much as we enjoyed producing it.

Marion Friedman, M.D.
Mary Ann Ayd ■

"*When World War II began, the scope of therapeutic activity of the sulfonamides was not clearly delineated; penicillin was a novel product, so far untried; and plasma and type O blood had been administered by only a few. In addition, the civilian physician, except in a few instances, was not familiar by training or experience with the large number of diseases peculiar to the tropical and subtropical climates. Furthermore, at the onset of the war, the overall problem inherent in the relation of the supply of specialists of various categories to the demand for them in civilian practice and in the Army had to be resolved. For example, the number of psychiatrists, epidemiologists, and specialists in tropical medicine and in the control and treatment of contagious diseases was woefully inadequate to serve both the civilian and military population. Accordingly, it was necessary to train Medical Corps officers in specialties required for military needs. This placed a peculiarly difficult burden on a large number of physicians who had to learn a new field of medicine, in which frequently they had no great interest, by means of short and intense refresher and training courses. The manner in which these problems were met deserves more recognition than these patriotic physicians will ever receive. The amazingly low morbidity and mortality in military zones occupied by U.S. troops showed how well the task of these officers was accomplished. The development of ideas and their application to the prophylaxis and treatment of disease in the Second World War fill a significant page in the history of medical science.*"

Mason VR. Central Pacific Area. In: Coates JB Jr, Havens WP Jr, eds. *Medical Department, United States Army. Internal Medicine in World War II. Activities of Medical Consultants.* Vol. I. Washington, DC: Office of the Surgeon General, Department of the Army; 1961:642-643.

Surgeon General of the Army

Born in Rising Sun, Cecil County, Maryland, in 1888, Norman T. Kirk served as Surgeon General of the Army from 1943 to 1947.

He received his medical degree from the University of Maryland School of Medicine in 1910. After serving an internship and surgical residency at the university hospital, he was commissioned a first lieutenant in the Army Medical Corps in 1912. During World War I, he was credited with treating at least one third of the major amputations in American troops, and later became an authority on bone and joint surgery. He developed a number of orthopedic surgery techniques, including a procedure known as Kirk's below-the-knee amputation. Discharged a lieutenant colonel after World War I, he was recommissioned in 1933 and promoted to brigadier general in 1939.

For his service as Surgeon General, he received the Distinguished Service Medal. He retired in 1947 with the rank of major general. Dr. Kirk died in 1960.

PREPARING FOR A REAL WAR

. . . . . .

Col. John B. De Hoff, M.C.

In June 1935, I was commissioned a second lieutenant, Infantry, U.S. Army Reserve, fresh out of Hopkins Reserve Officer Training Corps (ROTC). The political pot boiling in Europe foreshadowed a major war that eventually would involve the United States. I stayed in the Army. Shortly thereafter, many newly qualified officers were notified that the Army had infantry second lieutenants in excess and we had a choice of transfer from infantry to Signal Corps or Coast Artillery Corps. The latter had its headquarters in Fort Monroe, Virginia, a pleasant overnight boat ride from Baltimore—an admirable reason to choose it. I served four annual summer camps in the 913th Coast Artillery, an antiaircraft regiment. Upon graduating from medical school, I transferred to the Medical Reserve.

I received orders to report on October 20, 1941, to the Signal Corps center at Fort Monmouth, New Jersey. The orders stated this was for only one year of service, at the end of which we would return home. In our hospital and outlying battalion dispensaries, supplies of medical equipment were improving, although thermometers and fresh needles were still hard to come by. This never stumped the commanding officer, who said, "When I was in the Philippines, nurses just felt the soldier's head. If it felt hot, then she took his temperature, otherwise she entered normal." And that is what happened at Monmouth until supplies caught up with needs.

After the Japanese raid on Pearl Harbor, I was ordered to the newly expanded Army school of tropical medicine at Walter Reed Hospital in Washington, D.C., for the first two-month class of concentrated study. The faculty included several outstanding professors of medicine who showed us how to dissect mosquitoes and check the stomach walls for malaria parasites that clustered there. We leaned how to identify adult mosquitoes and larvae by physical

characteristics and were introduced to tropical disease details we had only briefly heard about in medical school.

That experience in tropical medicine changed my military career in World War II from a medical ward officer to a designated tropical medicine "specialist," or, later, a clinical laboratory officer. My first assignment on return was as the Fort Monmouth station hospital laboratory chief. At the same time, I had a medical ward through which came Jackie Cooper, the motion picture star, and from whom I caught rubella. Joseph Lockard, the Signal Corps soldier whose radar first detected the incoming Japanese planes at Pearl Harbor, was also my patient there.

Medical corps men assigned to dispensaries determined the blood type of each new draftee. Because a finger stick should bleed well, the dispensary had been issued sail needles, which are four or five inches long and have a broader blade than hypodermic needles. Many draftees fainted.

Anticipated orders for overseas duty arrived, and I was sent to Trinidad, British West Indies, in July 1942. I returned to the United States in February 1944 to be assigned to a medical pool at Fort Dix. From there, I was ordered to Camp Blanding, an infantry replacement and training camp in Florida, for duty as a neuropsychiatrist.

Much of the work there was routine examination of anxious and worried soldiers, not a few of whom were suspected of blatant goldbricking. Camptocormia was a diagnosis I had never heard of before and hardly ever have heard of since. It was so prevalent at Blanding that at one grand rounds, the orthopedic and psychiatric services presented 12 cases.

In early June, just before the D-Day landings at Normandy, I was ordered to travel south to Brooksville, Florida, to be the tropical medicine consultant for the Quartermaster Board's testing of tropical equipment. We had three medical teams in the field at all times, sited along the Weekewachee river, to simulate jungle medical care. Field units tested equipment for the tropics, including shoes, hammocks, and clothing customarily made of cotton, but now replaced by nonabsorbent nylon. Men suffered from miliaria, and elastic nylon allowed hammocks to sag and female mosquitoes could pierce through as many as three layers to find a blood meal. About the only important finding was that Byrd cloth, a tightly woven cotton twill, would resist mosquitoes. The trouble was that clothing made of Byrd cloth was unbearably hot. Testing had been done by 30 or so men sitting in a circle of folding chairs, observing the back of the man in front. The task: count the number of mosquito landings on your buddy's torso, which would be checked the next day for bites. Many landings and no bites meant the fabric was effectively resistant to the proboscis of a mosquito.

When this easy camp duty was over in September, orders took me and my family to Camp Rucker, Alabama, where I joined the 132nd Evacuation Hospital as laboratory and pharmacy officer. All around us were infantry, armor, and artillery units vigorously preparing for a real war, while we seemed to sit and think about it. Finally, on December 21, we said goodbye to our spouses and headed by a slow troop train to a then-unknown destination. Four days later, we arrived at Camp Kilmer, New Jersey.

Readiness preparations became more urgent, with fresh rounds of immunizations and even a practice descent from an icy simulated ship's deck using rope ladders. To help understand how to board a train, someone scratched out on Kilmer's frozen soil a pattern of the passenger cars we would ride to the port. On a bitterly cold day, we marched across the scratches to simulate loading aboard the train. When we did at last occupy the real train, we heavily laden officers sat quietly on the edges of our seats, waiting to get going. And when the train moved, it took us all the way to Hoboken—backward.

After a short ferry trip across the Hudson River, we were introduced to the liner *Brazil*. We were headed for Le Havre.

Ed. note: Dr. De Hoff remained in the U.S. Army Reserves until 1965, when he retired a colonel. Now retired from medical practice, he lives in Baltimore County. ■

Col. Thomas B. Turner, M.C.

A native of Calvert County, Maryland, Thomas B. Turner was an undergraduate at St. John's College in Annapolis during World War I. He was accepted at officers' training school at Plattsburg, New York, but the conflict ended before he could be activated. Upon graduation from St. John's, he entered medical school at the University of Maryland, graduating second in his class in 1925. He served a rotating internship at the Hospital for Women of Maryland (later united with others to form Greater Baltimore Medical Center) and then as chief resident in medicine at Mercy Hospital under Maurice Pincoffs, M.D. In 1927, he became a postdoctoral fellow in the department of medicine at The Johns Hopkins Medical Institutions; Dr. Warfield Longcope was the professor and Dr. Alan M. Chesney was his immediate preceptor. While working in Medicine I (the syphilis clinic) with Drs Chesney and Earl Moore, Dr. Turner became interested in the spirochete.

In 1929, Dr. Turner was chosen to go to Haiti, for Hopkins, which had undertaken a study of the spirochetal infection yaws. He arrived with a dozen monkeys and many white rabbits in which he was to try to establish strains of the spirochete. At that time, the average annual income in Haiti was $40 per family and there was a total of five miles of paved roads. Before long, Dr. Turner began to notice that his rabbits were gradually disappearing. Putting them under under lock and key, however, seemed to stem his losses. Because he had to carry his animals and laboratory equipment to all parts of the island to obtain spirochete samples, these conditions posed numerous difficulties. He nevertheless collected the material in about six months and returned to Hopkins to expand studies of the bacteria.

The International Health Division of the Rockefeller Foundation became interested in yaws in 1931, and it offered Dr. Turner the opportunity to head its activities in this field. The work took him back to the tropics, this time to Jamaica, a beautiful and prosperous island. The primary responsibility of his group, the Jamaica Yaws Commission, was to study the prevention and treatment of yaws with injections of neoarsphenamine and bismuth. Because there was no other medical facility on the island, however, members of the group soon became family physicians and treated all the illnesses. Dr. Turner spent three years in Jamaica and another three at the Rockefeller laboratories in New York, where he inherited the former laboratory of Hideyo Noguchi, a world renowned scientist who had succumbed to yellow fever in West Africa. (A vaccine for the highly contagious disease was in development then, and Dr. Turner was the twelfth person to receive the yet-untested vaccine.)

Dr. Turner returned to Hopkins in 1937, where he became director of the department of microbiology, first in the school of hygiene and public health, and later, as a combined department in the school of medicine. When war broke out in Europe, having made numerous friendships with internationally recognized scientific leaders, Dr. Turner became active in a committee of notables who were attempting to "Defend America by Aiding the Allies." In the spring of 1940, as the U.S. government prepared for the possibility of war, Dr. Turner was appointed to a highly confidential committee of the National Academy of Sciences, code named the WBC Committee, to evaluate the probability of our troops being subjected to bacterial warfare.

A three day conference of army preventive medicine officers was recently held at the School of Hygiene and Public Health, Baltimore, and was attended by representatives from the Office of the Surgeon General, service commands, army air forces and army ground forces. The purpose of the conference was to present recent developments in research and current policies and to afford ample opportunity for discussion of local preventive medicine problems and their solutions. . . . Topics discussed the first day were immunization, control of infectious diseases and insect control. The presiding officer was Col. Thomas B. Turner, assistant chief, Preventive Medicine Service, Office of the Surgeon General."

JAMA 1945;127:595

On December 8, 1941, the head of the preventive medicine division of the office of the Surgeon General of the Army asked Dr. Turner to join its service to head the venereal disease control activity. Having been criticized as lax in that area, the Army apparently wanted to appoint someone to a high rank to maintain respect, but without offending the regular corps officers. The Army therefore waited for Dr. Turner to attain his 40th birthday and appointed him the next day to a commission as a lieutenant colonel. The position posed many difficult problems that were not strictly medical (e.g., social mores; availability of opportunities for recreation, relaxation, and education) and truly satisfactory solutions were not always possible.

As the Allies began to reclaim more of Europe toward the end of 1944, the office of the Surgeon General selected Dr. Turner to head the Civil Public Health Division. His introduction to the post was a typhus epidemic raging in Naples. Activities contin-

The most important change in basic policy in connection with venereal disease control within the Army during World War II was the removal of punishment for acquiring a venereal disease. On 18 January 1943, The Surgeon General recommended that the law prescribing loss of pay or time for acquiring a venereal disease be repealed. The change recommended by this letter was revolutionary. It ran directly counter to established Army policy and conflicted with the opinion of numerous Army officers, particularly line officers. On no other issue was opinion within the Office of the Surgeon General so divided.

The basis for this punishment was founded on the premise that disciplinary measures and loss of pay were deterrents to exposure on the part of military personnel to venereal diseases. It was becoming increasingly clear, however, that this act [of the 69th Congress, 1926] was not achieving the objectives for which it was designed.

The Air Surgeon wrote that the application of this act was of particular concern to the Air Forces. Flying personnel were concealing the fact that they had contracted a venereal disease and were flying while receiving clandestine treatment involving the extensive use of sulfa drugs. The Air Surgeon cited the case of a flying officer whose death could reliably be attributed to anoxemia caused by the presence of methemoglobin resulting from the promiscuous use of sulfanilamide.

The memorable letter of 18 January 1943, in which The Surgeon General recommended repeal of the act of 1926, was prepared by Colonel [Thomas B.] Turner with the close collaboration of Colonel Morgan [Division of Professional Services, Office of the Surgeon General]. Highlights of the argument are summarized in the following paragraphs:

1. *With respect to the concealment of disease, self-treatment, and treatment by nonmilitary personnel, these practices usually mean inadequate and ineffective treatment, more frequent resistant cases and relapses, unnecessary loss of manpower, and a resultant increase in the spread of the disease.*
2. *The law is obviously unjust in that individuals differ in their reaction to treatment. Diagnosis is difficult and often impossible when just a few doses of sulfa drugs are taken. Furthermore, unlucky persons are branded with the stigma of being diseased due to misconduct, while others who escape are not. It is particularly unjust when an individual is liable to be punished if he fails to report the contracting of a venereal disease, is also absolutely certain of receiving punishment if he does report, and is removed from duty while being treated. The law also places the Army in a most incongruous position concerning inductees entering the service with a venereal disease. The Army accepts an inductee as qualified for military duty and then immediately hospitalizes him and under law deprives him of his pay. Moreover it is impossible to determine whether or not the infection is the result of misconduct inasmuch as the disease was contracted at a time when the inductee was not under military control.*
3. *This law influences the attitude taken on this whole subject, with undesirable side effects. For example, in some organizations, reduction in grade is made mandatory for noncommissioned officers who acquire venereal disease. The Army can ill afford to penalize itself by restricting the usefulness of men whose training may represent large investments in time and money and whose services are greatly needed.*
4. *When men are taken from the relative safety of their home environment and placed in situations where the risk of venereal infection is many times as great, the Government should be ready to assume a share of the responsibility, just as it has always done in the case of other diseases.*
5. *The advent of new drugs for the treatment of gonorrhea has materially shortened the course of the disease. Therefore, the monthly venereal disease inspection provided in Army Regulations No. 615-250 is inadequate to prevent concealment since the only cases of gonorrhea that are likely to be discovered are those which have recently developed or those which have not responded to treatment from unauthorized sources.*

On 27 September 1944, Congress enacted a bill repealing the provision included in the act of 17 May 1926 which provided for loss of pay for acquiring a venereal disease.

From: Sternberg TH, Howard EB, Dewey LA, Padget P. Venereal Diseases. In: Coates JB Jr, Hoff EC, Hoff PM, eds. *Medical Department, United States Army. Preventive Medicine in World War II. Communicable Diseases Transmitted Through Contact or by Unknown Means.* Vol. V. Washington, DC: Office of the Surgeon General, Department of the Army; 1960:143,145-146.

ued in North Africa and across Europe, primarily involving dusting with DDT. No other major epidemics occurred.

After the war, Dr. Turner returned to his position as head of microbiology at The Johns Hopkins School of Hygiene and Public Health. In 1957, he became dean of Hopkins medical school, a post from which he retired in 1968. He then became head of a foundation for the study of alcohol problems until 1989. Dr. Turner lives in Baltimore in the same home he has occupied for more than 40 years. He still goes to his office at Hopkins almost every day and regularly attends Saturday grand rounds.

MARION FRIEDMAN, M.D.

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CASUALTIES FROM THE WAR

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Capt. Joseph M. Miller, M.C.

I well remember that telephone call, which came about 3:00 p.m., December 7, 1941. I was in the office and Mary, my wife, called me from home. War, the unknown, had started, and the next four years were to be a period of uncertainty.

Initially, I helped in the induction examinations of the young men who were being called up to military service. Later, I became an active participant as a first lieutenant in the Medical Corps. A period of indoctrination on how to be an Army doctor followed in Arkansas and Pennsylvania and then I was transferred to the 6,000-bed Halloran General Hospital, which was being opened on Staten Island, New York.

There, we first received casualties from the campaign in North Africa. I was responsible for a ward of 50 to 60 patients. Some of the days were long because on many evenings we were alerted that a convoy carrying patients had docked. A long line of ambulances shuttled between the ship and the hospital and we might receive 500 to 1,000 patients at one time. A rapid triage was effected by the entire hospital staff and those soldiers who could be safely shipped further into the Zone of Interior were transported the following day. Sick patients were admitted into our hospital. Those needing further surgical care were prepared for operation.

As a general surgeon, I saw many patients with wounds I would never again encounter in later life. Included among our patients were German prisoners of war; we had 500 beds assigned for their care. They received the same care as did the Americans, and most of them were glad to have been taken prisoner.

One such boy of 18 I will never forget. He had sustained a wound of the left cervical region and had been operated upon in an American hospital in England. On the transport to the United States, he bled repeatedly from his

wound. When he arrived at Halloran, he was extremely pale and in surgical shock, with a low hemoglobin and blood pressure. Blood was started as soon as possible and resuscitation efforts were undertaken. Because of his great blood loss and poor condition, it was obvious that he would die unless we could stop the bleeding. We took him to the operating room about 6:00 a.m. that Sunday morning and with only a minimal degree of sedation reopened the neck wound to find the bleeding point. The major vessels anteriorly were intact and a lacerated left vertebral vein just medial to the anterior scalene muscle deep in the neck was found to be the culprit and ligated. He was given a private room with care, and he recovered fully. I told him once that his recovery was due in large part to blood donated by Hebrews, African-Americans, and other Americans. He accepted this bit of philosophy with good grace.

Another patient who had a great outcome was a soldier who had sustained a serious chest wound. When he was admitted to our hospital, he had a left pulmonary hernia and a 0.45 caliber bullet in the left, anterior myocardium. In the era before cardiac surgery was fully embraced, the removal of the bullet was an exciting event. I helped Maj. Thomas B. Wiper, M.C., the thoracic surgeon, remove the bullet and reconstruct the chest. The patient did well for many years.

Opportunity to study patients was never denied and was actually encouraged. At that time, most of our knowledge about pancreatic fistula and the bodily changes resulting from the loss of pancreatic fluid had been derived from animal study. The opportunity to study three such patients, one of whom had lost as much as 1700 cc per day, was a distinct occasion to learn some basic physiologic principles. Detailed studies demonstrated the considerable electrolyte loss produced by these fistulas. What is accepted as common knowledge now was then unexplored territory. The values for plasma proteins, sodium, calcium, and bicarbonate were seriously disturbed.

Severance of the urethra below the prostate in males is a challenging problem. In two patients at Halloran and one later in Korea during the time of occupation, we devised and used an effective method. The approach was twofold: through the perineum and through the bladder. A circle of catheters was made with one coming out suprapubicly and the other through the external urinary meatus. The catheters were united by silk sutures. These were left in place for about three to four weeks and then urethral dilation to a proper aperture by sounds was effected.

Ed. Note. Now retired from the practice of surgery, Dr. Miller lives in Timonium, Maryland. ■

MEDICAL SCIENCE ELIMINATING VENEREAL DISEASE

Such progress is being made by medical science against venereal disease that within five years syphilis and gonorrhea will be removed from the list of major health problems, according to Dr. Thomas Parran, Surgeon General of the U.S. Public Health Service. In an OWI report Dr. Parran stated that in the last eighteen months penicillin has had a "cure rate" of 96 per cent among all gonorrhea patients and also "cures some cases of infectious syphilis." The report dealt in detail with wartime health and problems to be expected when peace returns. There is no indication of a serious decline in the nation's mental and physical health, but Dr. Parran warned that the "lines against disease are lightly held." Shortages of medical manpower and the shifting population "leave us vulnerable to a breakthrough on many fronts." The shortage of doctors and nurses for civilians was expected to continue until both Germany and Japan are defeated. In the first ten years after the war the country will need 417,000 new hospital beds, including 191,000 for mental patients and 60,000 for the tuberculous. Installations of all the hospital beds and health centers which would be needed would cost almost $2,000,000,000, Dr. Parran estimated. Rural areas would have an urgent need for small, well equipped hospitals and health centers.

JAMA 1945;127:661.

Army Service, 1942-1946

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Lt. William W. Quivers

I started my senior year at Hampton Institute (now Hampton University) in Virginia in September 1941 with the strong feeling that I would be drafted into the Army before the end of the first semester. Hampton had entered into an agreement with the U.S. Naval Department to furnish students to participate in a bacteriology investigation program, primarily involving food poisoning. The program was set up to provide experience and training in bacteriology and both laboratory and medical technology. The bacteriologic activities were to be housed at the Navy's Craney Island Laboratories in Norfolk. The medical technology was located at the local Dixie Hospital, with which Hampton was affiliated for its nursing school.

On December 8, 1941, I received my draft notice ordering me to report in January for my induction physical examination. During the examination, the officer inquired about my activities. He became quite interested and recommended a deferral for me so that I could complete my studies. I heartily agreed. The deferral was granted and I finished school.

After graduation, I was hired by a hospital in Newport News, Virginia, to work in the laboratory while the technician was on vacation. The opportunity was arranged by my family physician and mentor. In August 1942, I received a letter from my draft board informing me that I had been returned to 1-A draft status. It was followed by a letter of induction effective August 25.

Along with a bus load of recruits, I arrived at Fort Meade, Maryland, about 3:00 a.m., on August 26. We were tested, received supplies, and attended lectures for two days, then loaded on a troop train at 10:30 p.m., and shipped out. During the morning of September 2, we were permitted to raise the shades and look out. This was our first sight of the Walla Walla State Penitentiary in Washington. At the train depot, we were loaded on trucks and taken to the Walla Walla Army Air Base.

I was assigned to the 49th Aviation Squadron (Sep). A few days later, the outfit was split. I remained with the 95th Aviation Squadron (Sep) in Washington; the 49th Aviation Squadron (Sep) was shipped to Kansas. I continued to think that some responsible person would look at my service record, see my laboratory experience, and transfer me to the Medical Corps. After about a week with no specific assignment, I was designated the squadron first aid clerk, a position that kept me in squadron headquarters.

I had been in the service about two months, when, one afternoon, I was sitting and reviewing the textbook we had used for our technology training; I was trying to keep my knowledge active. An officer, a friend of my commanding officer, observed what I was doing and asked if I knew that "stuff." I told him I had studied it in college and had worked in a hospital laboratory for about four months before being drafted. He asked if I would like to work in the base hospital in the afternoons if he could arrange it. I suggested that he clear the idea with my commanding officer. He agreed, reluctantly. I worked in the base hospital for about two weeks before my commanding officer was able to cancel the arrangement. He indicated that he wanted to send me to Officer Candidate School.

In October 1943, after repeating the Army General Classification and successfully appearing before the Officer Candidate Board, I was ordered to the Army Air Force Officer Candidate School in Miami, Florida. I was not sent to the program as a physical training candidate, however, and ended up being assigned to the Mess Officer Program as per the recommendation of the psychology officer. I graduated from Officer Candidate School with specialty numbers classifying me as an administrative and mess officer. My orders sent me to Tuskegee Army Air Field, Tuskegee, Alabama, where I arrived, along with five classmates, in February 1944. We were newly commissioned second lieutenants.

In January 1944, the Army had established a policy assigning all African-American graduates from the officer candidate school to Tuskegee. A previous policy had alternated between Tuskegee and Selfridge Field, Michigan, where the pilots (Tuskegee graduates) rounded off their training and finally formed the 99th Pursuit Squadron and later, the 332nd.

My first assignment at Tuskegee was as one of several assistants in an organization attached to the Cadet Training School. After about two months, I was appointed Base Processing Officer for the field, a newly created position in the service. I was the first one to hold it. I had to formulate a protocol for examining the records, equipment, and supply items of every officer and enlisted man leaving the base on assignment. I also examined the records of military personnel coming to the post. After about five months in this job, I was replaced by a higher ranking officer. I was transferred to the unit that serviced the airplanes for the pilots and student pilots, at the request of that unit's commanding officer. My assignment was to update the records of the enlisted personnel. The records were atrocious. Involving all entries in each soldier's personnel record (medical, payroll, supply, equipment), the assignment was the most difficult one I had to handle, and I had numerous discussions with the commanding officer, a captain.

My appointment to this position lasted a little more than two months. The commanding officer of the Cadet Pilot Training Corps requested my return to his command, since I was "on loan" as the Base Processing Officer. On my return to the Cadet Corps, I was assigned the position of Assistant Supply Officer. After about three weeks, I was appointed Supply Officer, a position I maintained until the unit was deactivated in late July 1946. I was discharged September 3 with the rank of first lieutenant.

Ed. Note: A graduate of Meharry Medical College, Dr. Quivers is retired from the practice of pediatrics. He lives in Baltimore. ■

A 1945 list of the most important remedies might be:

1. Penicillin and the sulfonamides and antibiotics.
2. Whole blood, blood plasma and blood derivatives.
3. Quinine and quinacrine.
4. Ether and other anesthetics, morphine, cocaine and the barbituric acid derivatives.
5. Digitalis.
6. Arsphenamines.
7. Immunizing agents and specific antitoxins and vaccines.
8. Insulin and liver extract.
9. Other hormones.
10. Vitamins.

JAMA 1945;127:593

Letters from Home

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Caroline Bedell earned her undergraduate degree at Smith College and her medical degree at The Johns Hopkins University School of Medicine in 1930. In 1934, she married Henry M. Thomas, M.D., a fourth-generation Baltimore physician. The year their third child was born, Dr. Henry Thomas became the first service command medical consultant to go on duty with the U.S. Army during World War II. From 1941 to 1952, Caroline Thomas, M.D., was an assistant professor in the department of medicine at Hopkins. From 1935 to 1942, while physician in charge of Hopkins' Adult Cardiac Clinic, she did pioneering work in the use of sulfanilamide as a prophylactic treatment in rheumatic fever. She served as a civilian consultant in infectious diseases to the Surgeon General of the Army from 1944 to 1946. Of the 25 civilian medical consultants, she was the only woman and the only physician from Maryland. Now retired from the practice of medicine, Dr. Thomas lives in Baltimore. Following are excerpts from letters she wrote to her husband while he was stationed in the Pacific (*used with permission*).

. . . . . .

Feb. 2, 1944

Harry and I were properly thrilled, sympathetic or entertained, as the case may be by your talk of slit trenches, daisy-cutters, torrential downpours and holes for gluteals et al—Sorry your disc has been so pounded around by jeeps.

Hugh Morgan wrote me an official letter today which came just as I was leaving, asking me to be a civilian consultant to the Surgeon General, or rather, the Secretary of War, in view of my distinction in internal medicine and infectious diseases in particular. Very good fun. Good old rheumatic fever is still working for me, even if I'm not working for *it* any more.

Feb. 27, 1944

Going to Emily Randall's today for lunch with Sally Bowditch, Capt. W.A.C., who is in charge of all the V.D. in Fort Ogelthorpe, male and female. She has even shocked Earle with her new job! She thanks fortune for a reliable Army Sergeant who goes about at night with her exploring and who gives local Rx.

. . . . . .

Sept. 27, 1944

What do you think of me being off to a Consultant Conference end of October? Sounds like fun, and probably will be as close as I'll ever get to being in the Army Medical Corps. Lucky I know a little about Army Protocol.

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Oct. 21, 1944

My 'orders' have come to go to White Sulphur Springs—real Army ones in quadruplicate, plus instructions as to how to get my ticket and proceed—as much paper as in a whole magazine just to tell one girl how to take one short trip. No wonder there's a paper shortage! Also, the program has come—I'll send it to you when I get my hands on a copy. Quite a lot about rheumatic fever, and about prophylactic diazine for respiratory infections. Norman Kirk gives opening speech and Hugh Morgan, the closing one.

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Nov. 1, 1944

I am just back from 3 nights - 2 days trip to Ashford Gen. Hosp. where 19 civilian consultants and about an equal no. of the military met in solemn conclave. We sat in plenary session around a U-shaped table.... Gen. Kirk and Gen. Bliss opened the meeting, stayed all the first day, not the second.... Gen. Kirk was very vigorous, and expects every doc to do his duty. (He knows that you are.) Gen. Bliss is very nice. The first morning was devoted to problems of hospitalization. Walter Bauer put his oar over proper use of dispensaries, and

Letters from Home

E.V. Allen of the 7th S.C. over 'The O'Reilly General Plan' of working up as many as possible while housed in barracks, conserving hosp. beds and consultants' time. Eli Ginsberg, statistician to Gen. Bliss, held forth, as did Col. 'Gus' Thorndike, Director of the Reconditioning Division. Dr. John Stokes gave a most extraordinary talk on a New Guinea dermatological entity... illustrated by many slides just rec'd from N.G.—and the last one, 'the worst case in New Guinea' was a slide of you among the banana fronds! Everybody clapped and laughed—you looked very cheerful. Hugh was much tickled—they had planned it as a wonderful surprise.... I had a long talk with Hugh that night...he thinks you and MacArthur will be together till the cows come home.

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Jan. 14, 1945

What great events you are taking part in! MacArthur's brilliant landing on Luzon this week has thrilled and heartened everybody, coming as it does at a rather bleak period of the Western Front Battle. I don't suppose you actually took part in the landing, but I know how recently you have been with the Sixth Army, and how closely bound up in this big battle for the Philippines you are.

. . . . . .

Apr. 15, 1945

The President's death on Apr. 12th has been a great shock to everyone. You probably heard of it nearly as quickly as we did...

Perhaps you saw the newsreels of the President after his return from Yalta—where he addressed congress sitting down? He certainly was strikingly changed—had lost weight and showed evidence of generalized disease—I guess arteriosclerosis. Perhaps Truman will be another Calvin Coolidge—accounts of him are quite favorable....We have had two days of mourning—yesterday and today. All stores and gas stations closed, and no 'program' over the radio—just talks and wonderful music. It has really been a wonderful relief from the usual goings on.

. . . . . .

Aug. 11, 1945

All over the world people are waiting and hoping tonight—and what a hope! If Japan accepts Byrnes' ultimatum making their Emperor a puppet under our military rule, then the whole ghastly business is over—at least, the fighting part...You bet I'm glad you told me you were coming early—it has made us all happily expectant, but I know the Army well enough not to have pinned my hopes on any one date. You haven't upset us by delay—we're just getting used to the idea and enjoying the pleasures of anticipation.

Shortly after the outbreak of World War II, Sarah H. Bowditch, M.D., volunteered for a position overseas with the Emergency Medical Service under the British Ministry of Health. She served there as a medical officer from 1941 to 1942. She returned to the United States at the request of The Johns Hopkins University, where she served as an assistant visiting physician in 1942-1943. In November 1943, she accepted a commission in the U.S. Medical Corps and returned to London as the Assistant Military Attache at the American Embassy, the first woman to hold that post in the embassy's history. A 1935 graduate of The Johns Hopkins University School of Medicine, she was awarded the Bronze Star when she left the service in 1946. Dr. Bowditch died in 1966.

Jane Short

Bibliography

JAMA 1945;128:4.
Newspaper clippings provided by The Alan Mason Chesney Medical Archives of The Johns Hopkins Medical Institutions. ■



Civilian Consultants to the U.S. Army in World War II: White Sulphur Springs, 1944.

L-R (1st row, seated): Col. Pillsbury, Col. Strong, Col. Noyes, Gen. Morgan, Col. Beck, Col. Freer, Col. Holbrook.

2nd Row: Lt. Col. Sternberg, Col. Allen, Col. Fitzhugh, Col. Bauer, Dr. Stokes, Dr. Palmer, Dr. Moore, Col. Wright, Dr. Boyd, Dr. Watson, Col. Shull, Dr. White.

3rd Row: Col. Mason, Col. Adams, Dr. Levy, Dr. Thomas, Dr. Cook.

4th Row: Col. Dieuade, Dr. Jones, Col. Blumgart, Dr. McLeod.

5th Row: Dr. Wood, The Unknown Soldier, Maj. von Ravensway.

6th Row: Col. Baker, Col. McGuire, Dr. Brown.

7th Row: Dr. Rackeman, Col. Denny.

To Grow Strong

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Ernest O. Brown, M.D.

The storm clouds of war and preparations for it were already much in evidence in 1941. The build-up of munitions to be sent to Europe to help Great Britain endure and fight back against the bombardment by Germany was very much burnished in the mind a boy looking forward to going to high school. In 1941, I finished elementary school in the rural, sandy village of Town Neck (Severna Park), Maryland, and entered Wiley H. Bates High School in Annapolis that September.

At that time, I was too young to participate in the war activities, except to buy "War Savings Stamps" with money made from chores such as mowing lawns and gathering crops. In school, all students had to be involved in physical education classes to grow strong for the armed services. I now laugh because I had trouble reaching 130 pounds to play with the varsity football squad. We were also trained to be junior air raid wardens by the Civil Defense people who came to the schools and churches.

During the first two years of World War II, especially after I listened on the radio to President Franklin D. Roosevelt on December 7, 1941, announce the attack on Pearl Harbor and America's entry into the war, I participated in interscholastic football and baseball, studied hard and expectantly, and remembered Pearl Harbor. I was constantly on the lookout for warplanes and Japanese landing from little submarines on the Magothy River.

In 1942, I got a job at Hawkin's Point building the pier, but when my father caught me doing this dangerous work (carrying creosoted lumber and timbers over precarious footing over the water), he told the foreman my age, and I was dismissed. In August 1943, I was old enough to get a work permit, and I went

to work for Rustless Iron and Steel Company, where I worked at the blast furnace. I was so proud of the "E" for efficiency pin they gave me that I showed it all around school and soon lost it. Clean jobs were not available in Maryland to Negro youth, regardless of their ability, and we were eminently aware of it. I also worked at Fort Meade hospital as a janitor, at Holtite Shoe Company making soles and heels, and at the U.S. Printing Company cleaning presses.

On two occasions, I tried to advance my age and enlist in the armed services. On the first try, I was told something embarrassing like, "Go home to your mother, son." I was a whiz at aeronautical science in high school, so the second time I was trying for the Army Air Corps. I was separated out for praise on the written examination, only to be told at Bolling Field that I had failed the eye examination. My last summer job before the end of the war was for the B & O Railroad as a janitorial porter. By the time the bombs were dropped on Hiroshima and Nagasaki, my dream had already shifted from joining my brothers in the Army to becoming a chemist.

Ed. Note: A general surgeon who practices in Baltimore, Dr. Brown earned his medical degree at the University of Maryland School of Medicine. He served in the Air Force from 1957 to 1959; he was discharged a captain. ■

THE AMERICAN College of Radiology announces that the production schedules in film allotments for the third quarter of the present year indicate that quotas for civilian physicians and hospitals have been appreciably increased. WPB allotments for civilian consumption of medical radiographic film during the last quarter of 1944 amounted to 9.2 million square feet. Owing to the fact that manufacturers were unable to meet these schedules, only 9 million square feet was actually shipped. In the first quarter of 1945, 9.7 million square feet was allotted for civilian consumption. Total shipments were 9.2 million square feet. Shipments for the second quarter of 1945 are not yet known, but it is undoubtedly somewhat less than the 9.4 million square feet allotted. For the third quarter of 1945, 10.6 million square feet has been allotted for civilian health services. If manufacturers are able to meet these schedules, radiologists should be able to obtain almost all the film they require, assuming that they effect all possible economies. The college estimates that 11 million square feet per quarter would meet minimum requirements of civilian physicians and hospitals. The allotment for the Army and Navy for the third quarter is not definitely known. For the army industrial program, 5 million square feet has been allotted for ordnance inspection. UNRRA will receive 500,000 square feet. The quota for FEA and Lend-Lease has been sharply reduced. It is estimated that about 24 million square feet of medical radiographic film will be produced during the third quarter. Radiologists who are unable to obtain sufficient film to maintain their services should continue to report their cases to the headquarters of the college. All such cases will be referred to the proper officials of the WPB.

JAMA 1945;128:965

Maj. Theodore E. Woodward, M.C., is the lead author of a clinical laboratory study of 30 patients with severe epidemic typhus in which it was concluded that altered physiologic state consists primarily of an inadequate circulating blood volume, hypoproteinemia, hypochloremia, hemodilution without blood destruction, and an azotemia. Investigators also concluded that the circulatory collapse is primarily of peripheral origin; that general supportive measures to increase circulating blood volume are most beneficial; and that cardiac drugs (digitalis and allied preparations) are probably beneficial only in cases with clear evidence of congestive heart failure (*JAMA* 1944;126:287–293).

Capt. Joseph M. Miller, M.C., is the lead author of a study of the physiology of the pancreas in three patients with external pancreatic fistula. Investigators report a marked alteration in water balance, plasma protein level, and plasma electrolytes, and that sodium loss produces a clinical syndrome similar to that described by Addison. They found that administration of adequate amounts of sodium and water in the presence of sufficient plasma protein to hold them in the circulation alleviates the symptoms peculiar to this syndrome. They found that, although a number of drugs diminish pancreatic secretion through the fistula, ephedrine and sodium bicarbonate are less likely to have unpleasant or deleterious side effects. They also report that large amounts of ionizable calcium are normally returned to the gastrointestinal tract through pancreatic secretion (*Ann Surg* 1944;120:852–872).

Col. Henry M. Thomas, M.C., is the author of a report on the treatment of fulminating meningococcic infections. Stating that the three major objectives of treatment are to combat bacteremia, toxemia, and shock, he advocates the use of intravenously administered sodium sulfadiazine and sodium lactate, intravenous meningococcal antitoxin, plasma, isotonic sodium chloride, and aqueous extract of adrenal cortex (*Bulletin of the U.S. Army Medical Department* 1944;3:78–84).

Victor A. Najjar, M.D., George A. Johns, M.D., George C. Medairy, M.D., Gertrude Fleischmann, M.D., and **L. Emmett Holt, Jr., M.D.,** are the authors of a 3-month study of riboflavin biosynthesis in 12 male subjects aged 10 to 16. The subjects were given a diet of purified vitamin-free foods with only supplements of pure vitamins. The diet contained between 60 and 90 micrograms of riboflavin per day. Investigators conclude that riboflavin may not be a dietary essential under all conditions and question the high and universal requirement for this factor that has hitherto been accepted (*JAMA* 1944;126:357–358).

Walter E. Dandy, M.D., of the Johns Hopkins Hospital, is the author of a report on the treatment of spondylolisthesis in which he concludes that spondylolisthesis and defective intervertebral disks are identical in origin and that treatment for both is the same: complete removal of the disks. He states that the end result of the removal of the disks is fusion of the opposing vertebrae and therefore stabilization of the spine, which obviates the necessity of fusion by bone grafts to the spine. He concludes that spinal fusions by grafts are never indicated either for spondylolisthesis or for defective intervertebral disks; he states that their continued use means that the disks have been improperly recognized or treated, or both (*JAMA* 1945;127: 137–139).

Alfred Blalock, M.D., and **Helen B. Taussig, M.D.,** of the Johns Hopkins Hospital, are the authors of a report on the surgical treatment of cardiac malformations involving pulmonary stenosis or pulmonary atresia. Their technique for increasing the flow of blood through the lungs and thereby reducing cyanosis consists in making an anastomosis between a branch of the aorta and one of the pulmonary arteries. Abnormalities the authors believe should be benefitted by this type of surgery are the tetralogy of Fallot, pulmonary atresia with or without dextroposition of the aorta and with or without defective development of the right ventricle, a truncus arteriosus with bronchial arteries, and a single ventricle with a rudimentary outlet chamber in which the pulmonary artery is diminutive in size (*JAMA* 1945;128:189–202).

Houston S. Everett, M.D., associate professor of gynecology at The Johns Hopkins University, is the author of *Gynecological and Obstetrical Urology*, published in 1944 by The Williams & Wilkins Company (517 pages, $6.00).

J. Mason Hundley, Jr., M.D., and **William K. Diehl, M.D.,** of the department of gynecology at the University of Maryland School of Medicine, are the authors of a report on the influence of gynecologic disorders on the urinary system. Among the factors discussed are pressure exerted by pathologic processes due to pregnancy or large pelvic tumors; pathology of the urinary tract as a result of parturition; and the effect of pelvic infections on the urinary system (*JAMA* 1945;127: 572–579).

Curt P. Richter, Ph.D., of the Phipps Psychiatric Clinic in Baltimore, is the author of a report on the incidence of rat bites and rat bite fever in Baltimore from 1939 to 1943. Data are presented for 87 persons treated for rat bites or their sequelae at the Johns Hopkins Hospital. Of the 87, 65 (75%) came from an area of less than 2 square miles surrounding the hospital. All victims were bitten, usually on the face and hands, while asleep. Patients' ages ranged from two months to 65 years; 60% of the patients were under 1 year of age. The author concludes that rats regard sleeping humans as a source of food.

Joseph Earle Moore, M.D., is the coauthor of a report on the clinical diagnosis of uncomplicated syphilitic aortitis. The authors state that in diagnosing uncomplicated syphilitic aortitis in a patient with known late syphilis in whom hypertension, extensive arteriosclerosis or rheumatic heart disease are not present, the following symptoms and signs should be looked for: roentgenologic demonstration of dilation of the first portion of the aorta, heart failure or lowered cardiac reserve in the absence of hypertension or valvular disease, localized substernal pain (to be differentiated from anginal pain), and characteristic changes in the second aortic sound (*American Journal of Syphilis, Gonorrhea & Venereal Disease* 1943;27:711-715).

Marion Friedman, M.D., is the lead author of a case report and literature review indicating that eosinophil (eosinophilocytic) leukemia may indeed be an entity distinct from myelogenous neutrophil leukemia. The authors conclude that their case and 12 others found in the hematologic literature seem to be best characterized as manifestations of leukemic overgrowth of the eosinophil blood cells, but admit that the nosologic basis for this interpretation rests solely on morphologic evidence (*Am J Med Sci* 1944:208:333–343).

Emil Novak, M.D., an associate in gynecology at The Johns Hopkins University School of Medicine, is the author of the second edition of *Textbook of Gynecology*, published in 1944 by The Williams & Wilkins Company (708 pages, $8.00).

Thomas B. Turner, M.D., is the lead author of a report on the management of venereal diseases in the Army. Routine treatment of syphilis now consists of 40 injections of arsenoxide given twice weekly with additional injections of bismuth, covering a total of 26 weeks. More than three-fourths of all patients with uncomplicated gonorrhea respond to one or two courses of a sulfonamide drug. Penicillin promises to change the status of gonorrhea to that of an inconsequential infection; sulfonamide-resistant gonorrhea should no longer be a problem, and long continued treatment or fever therapy should no longer be necessary (*JAMA* 1944;124:133–137).

Caroline Bedell Thomas, M.D., is the author of a review of data on the prevention of rheumatic recrudescences in rheumatic subjects. She states that small daily doses of sulfonamides seem to be the most effective preventive method that has yet been found and advocates giving such prophylaxis to all children and young adults who have had one or more unequivocal attacks of acute rheumatic fever. She believes sulfadiazine to be the drug of choice, although sulfanilamide affords just as efficient protection and is not significantly toxic in low doses (*JAMA* 1944;126:490-493).

Cite SEER

Although death by taking an overdose of amphetamine sulfate has been rarely reported, a recent case report (*JAMA* 1945;128:1098-1099) suggests that **the indications for amphetamine sulfate should be carefully evaluated before it is prescribed for narcolepsy, torticollis, and other neuropsychiatric conditions.** A soldier was referred for neuropsychiatric consultation because his score on the Wechsler Intelligence Test was 150 despite only 8 years of schooling. His history included periods when he felt "blue," during which he drank heavily. He was given frequent interviews, and therapeutic reading was prescribed as well as amphetamine sulfate to mitigate his avowed feeling of depression. On April 18, the patient stated he had no difficulty sleeping, but complained of loss of appetite. He was instructed to take only 5 mg amphetamine in the morning and continue with that dosage. That evening he complained of feeling ill and was admitted to the hospital. A search of his possessions revealed a suicide note in which he admitted having taken four pills and described his intention to continue taking 4 at a time. Despite monitoring of his vital signs and treatment with caffeine, sodium benzoate, and oxygen, the patient died early the next morning. Cause of death was subdural and subarachnoid hemorrhage of the parietal and occipital lobes following the ingestion of an estimated 120 mg amphetamine sulfate taken with suicidal intent.

White and Scoville (*N Engl J Med* 1945;128:546) state that **trench foot and immersion foot are similar clinical entities that differ from frostbite in the type of exposure and the reaction of the tissues and their method of recovery.** Three stages are described: the initial response to cold, short of actual freezing of tissue cells, the early period of recovery, characterized by painful hyperemia, and the residual effects of fibrosis. The initial treatment is similar to that for burns but should include cooling to reduce the oxygen demands of the skin to a level compatible with the flow of blood through damaged subcutaneous vessels. Late treatment consists in conservative minimal amputations, exercises and physical therapy to decrease tissue fibrosis and joint stiffness and sympathectomy in selected cases with residual circulatory insufficiency. Gangrene of the toes and distal portions of the feet constitutes a serious problem in trench foot but is rare in immersion foot, in which the lower extremities are less liable to trauma and infection. Prolonged partial disability is frequent in both conditions. **Improvement in protective clothing, widespread instruction in foot care and first aid and a critical evaluation of the response of the fibrosed tissues to sympathectomy are in order** (Abstract published in *JAMA* 1945;128:546).

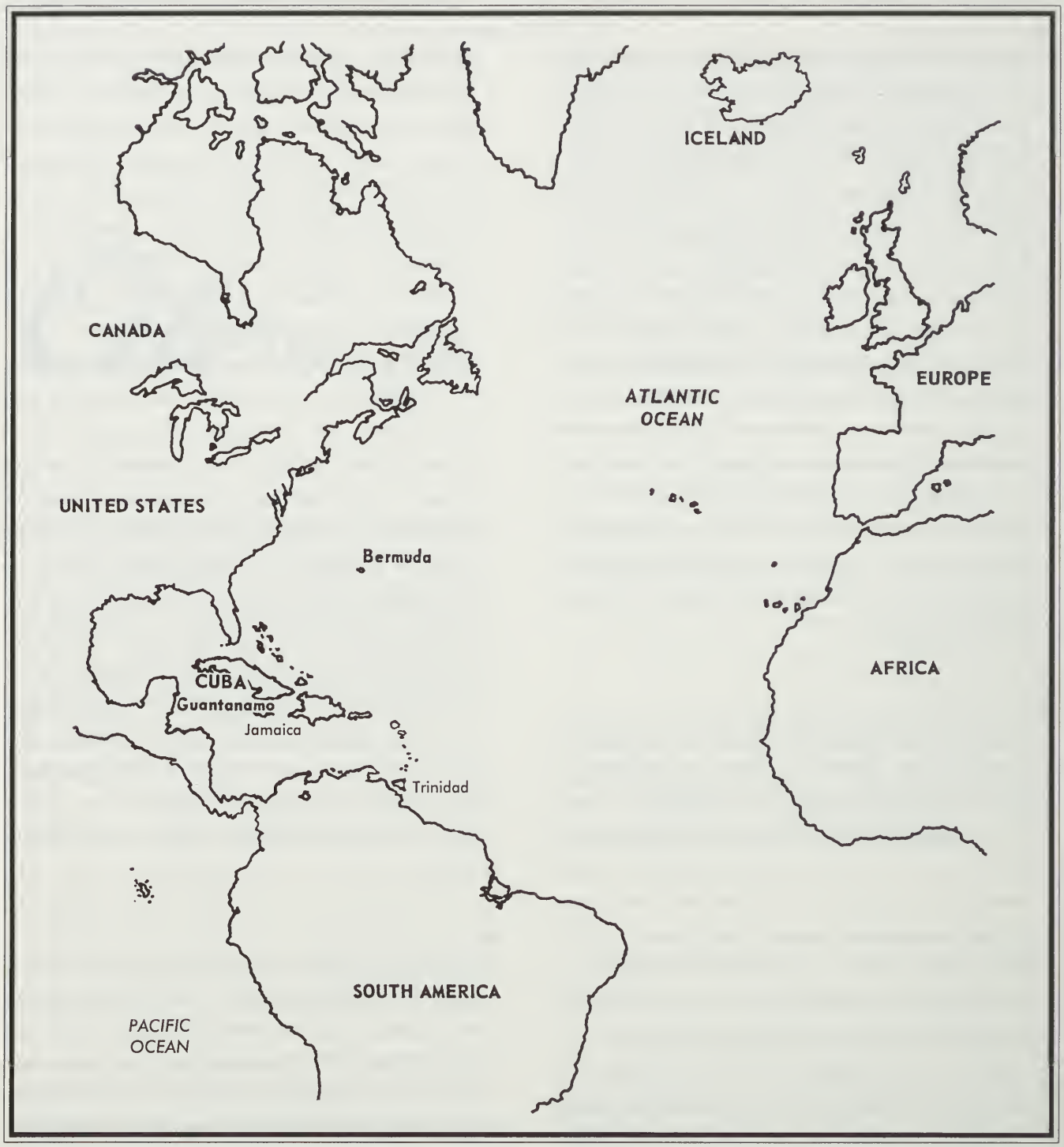
In the first of Short's series of nine cases of atypical pneumonia (*United States Naval Medical Bulletin* 1944;43:974) the administration of penicillin led to a sudden and sharp temperature decline, disappearance of symptoms and rapid convalescence. Eight additional cases have been treated, all of which responded more or less promptly to the drug. A control series was not observed, but **results with penicillin seemed to be much superior to those with the expectant, symptomatic treatment formerly used.** The average number of days from the institution of penicillin therapy until the temperature became normal and remained so was 3.5. This is decidedly less than the usual expectancy with supportive treatment (Abstract published in *JAMA* 1945;127:491).

In a study of the psychiatric reaction to amputation in 100 soldiers (*JAMA* 1945;128:645-652), **investigators found that those with upper extremity injuries, married men, and older men have less trouble in social adjustment.** Signs of psychopathology in terms of personality change, anxiety, emotional instability, battle dreams, and alcoholism occur in a surprising percentage of these men. Phantom sensations of some type occur in 95%. The investigators also report that **the importance of a stable wife, sweetheart, or mother is enormous.** Those who visit the injured soldiers and show the normally expected excitement at the reunion and accept the injury as an unfortunate but unimportant incident give a tremendous boost to their morale. **The dramatizers, the weepers, and the rejecters add further burdens to the soldier, who should be protected from such foolish behavior.**

Levine (*Am J Public Health* 1944;34:1274) reports the **results of an attempt to cause an epidemic of mumps in a private school of 161 children.** Out of 114 susceptible children exposed, 62 contracted the disease within a period of three months. Six of these developed complications. There were 4 cases of mumps encephalitis, 1 case of orchitis and 1 of probable mild pancreatitis. A questionnaire was sent out requesting complete information on the children who contracted the disease, with an added question as to whether any other members of the family contracted the disease. The final analysis **revealed that besides 1 teacher, who was incapacitated with the disease for two weeks, 10 parents suffered from the infection, a possibility which was completely overlooked when the plan was suggested.** It is doubtful that any further epidemics will be sponsored by the school (Abstract published in *JAMA* 1945;127:545).

McGarrahan (*N Y State J Med* 1945;45:193) presents case histories which further contribute to facts pointing to an interrelationship between chickenpox and herpes zoster. Treatment of chickenpox with intravenous thiamine hydrochloride brought the disease to an abrupt end in about six hours. He relates the coincidence of acute anterior poliomyelitis, herpes zoster and chickenpox in 3 members of the same household. A girl aged 6 with acute anterior poliomyelitis made unusual progress when given 50 mg thiamine hydrochloride and 150 mg niacin intravenously during the acute stage. **The value of thiamine hydrochloride in the treatment of herpes zoster is well established. Its value in treating chickenpox is strongly indicated here. Its use in infantile paralysis is an opportunity not to be overlooked.** The niacin in the case presented may have been as important as the thiamine, but it is fair to assume, in view of the role of thiamine in the maintenance of nerve function, that its importance is primary and that the patient with infantile paralysis faces a better prospect with an available (parenterally administered) excess of thiamine than with a deficit (Abstract published in *JAMA* 1945;127:1020-1021).

During the epidemic of poliomyelitis in 1943, 6 women with poliomyelitis were admitted to the Milwaukee Isolation Hospital (*Am J Med Sci* 1945;209:382). The fact that 4 were pregnant seems to indicate that pregnancy increases susceptibility to poliomyelitis. Increased susceptibility during pregnancy may be due to the change in ovarian secretion at that time, although primary dysfunction and fetal hormones upsetting the mother's balance may also be suspected. In the 4 cases of poliomyelitis complicating pregnancy, delivery of 2 normal children and examination of 1 fetus in a dead mother confirmed the opinion that poliomyelitis in the mother had not affected the newborn child, nor does it prevent normal spontaneous delivery (Abstract published in *JAMA* 1945;128:386).


ICELAND
CANADA
EUROPE
ATLANTIC
OCEAN
UNITED STATES
Bermuda
CUBA
Guantanamo
Jamaica
AFRICA
Trinidad
SOUTH AMERICA
PACIFIC
OCEAN

In the Trinidad Sector

Col. John B. De Hoff, M.C.

Having been trained by the Army as a tropical medicine specialist, I finally received anticipated orders for overseas duty. I was being sent to Trinidad, British West Indies ("but don't tell anyone"). My pregnant wife and I flew to the embarkation port at New Orleans, celebrated our fourth wedding anniversary there on July 9, 1942; the same day, we said goodbye and I departed aboard the Army transport *John Clem*. We sailed down the Mississippi and headed for Key West, where we were to pick up some Navy protection and sail in a small convoy to Trinidad. It was after dark when the ship arrived at Key West. Unable to enter the harbor because of its ring of mines, the *John Clem* circled slowly in safer waters. In the dark, the ship ran aground and we had to wait for the morning tide to free us. When it was light we could see the superstructure of another vessel that had struck a mine and sank.

In June 1942, the crew of one German submarine had learned that the 155 mm field guns of an artillery battalion that protected the entrance to Trinidad's harbor could not be deflected or lowered enough to be a danger to U-boats going through the narrow channel into Port of Spain. The submarine impudently surfaced and entered boldly through the harbor's entrance in full view. After torpedoing two merchant ships in the harbor, the sub turned and departed, still without submerging. In July and August, we seemed daily to receive survivors of a ship sinking in the southern Caribbean. One of the more fortunate seamen had been pinned to the deck of his slowly sinking ship by the wing of an airplane being shipped to Russia. He saw himself headed for slow drowning until, as the ship sank, the plane floated off his leg and he could swim to safety.

When the *John Clem* and two other transports left for Guantanamo Bay, Cuba, we were carefully escorted by a World War I destroyer, an old

four-stacker recalled from storage, and four private yachts converted to corvettes. We were the first convoy out of Key West to cross the Caribbean. Although our trip was uneventful, the sea routes were a shooting gallery for German U-boats: during the summer of 1942, at least one merchant ship or tanker was being sunk every day.

Port of Spain, our destination, was a major harbor for sea traffic headed for South America and Africa or returning to the United States. Trinidad was the southern anchor of Caribbean air and sea defenses and a refueling stop for large new bombers en route to Europe via Belem, Ascencion, and Dakar. It often provided a temporary home for as many as 75 or 100 ships. Here was the Army's Trinidad Base and Sector Command that protected the British, Dutch, and French Guianas, as well as islands to the north such as Saint Lucia and Grenada. Trinidad was important because it processed the aluminum ore, bauxite, that was being shipped from Dutch Guiana to the United States. Here, too, 100 octane gasoline was refined from oil pumped out of wells in southern Trinidad. The U.S. Navy had a base on the northwest corner of the island, and all services watched the Vichy French island, Martinique, from a base in Saint Lucia.

One of our older physicians had a special remedy for soldiers suspected of malingering. He prescribed a mixture of assafoetida, gum acacia, chloroform, and castor oil. A dose tasted and smelled horrible. The gum acacia caused it to cling to teeth. The chloroform caused belching and a repeat of the bad taste; it also promoted the passage of malodorous flatus. The castor oil caused diarrhea foul enough to disgust the soldier's barracks mates. For those who returned the next day, the complaint had to be taken seriously.

The 150-bed, 255th Station Hospital to which I was assigned provided care for the nearby garrison and other Army patients or U.S. civilian workers transferred from outlying bases. It had been hastily erected by persons not familiar with hospital needs. Wards had no running water, latrines were a short walk away, and litter patients had to be lifted by corpsmen over their heads to negotiate narrow doorways. No security, such as locked doors, existed. Only the operating rooms had glass windows; all other areas were merely screened.

I was immediately made the laboratory officer and physician in charge of two malaria wards. Patients with malaria who suffered chills and fevers to 106 degrees were nearly commonplace. Their fevers were easily remedied with two aspirins and sponging, and we had no deaths from malaria in Port of Spain patients. The blood slides that accompanied two patients air-evacuated from Saint Lucia, however, showed heavy parasitemia that medical officers on that island could not identify. An Army nurse who had been a trained laboratory technician in civilian life easily made the correct diagnosis, but the patients died. Although it seemed as though a scientific article should be written about malaria in Trinidad, when I re-

One evening, a new medical officer stopped by my office and asked what the medical officer of the day was supposed to do. Among other things, I told him he would be expected to provided obstetrical anesthesia. "But, I'm a dermatologist," he protested. Having done the anesthesia once or twice myself, I told him like an expert what he had to do. As we were talking, the duty sergeant came in and told the new medical officer that he was wanted in OB to give anesthesia. With a shrug and a sigh, off went the new anesthesiologist.

viewed several thousand cases, not much could be gleaned from the records other than that none of the patients had leucocytosis greater than 10,000. Most of the malaria we saw was vivax, but there was much falciparum and a few quartan cases.

Early in 1943, the 225th took over all of the hospital buildings recently evacuated by the U.S. Engineering Department. I now had the roomiest laboratory on the island. It had five rooms and was open on all sides except for a central storage closet that we began to use for dark field examinations of suspected luetic chancres. Laboratory services now included a morgue with six refrigerated boxes. My staff fortunately included a soldier who had been a morgue technician in civilian life. I performed 26 autopsies, four as a forensic pathologist, enough to assure me that I did not want to do medical examiner work. Corpses deteriorate too rapidly in the moist tropics. Now and then, however, something different did occur. Once we found a .45 caliber slug in a pelvic bone, far away from the thoracic entry point. Another time we came across a yellow Atabrine tablet in a lung's cut surface, the result of an ante mortem, possibly terminal aspiration.

> Like many laboratories, ours had multiple tasks and some perquisites. We made batches of chocolate syrup or chocolate milk, but had trouble keeping them for long in the lab refrigerator because chocolate syrup was nearly impossible to obtain. So, we thought we should tell everyone our recipe. In a laboratory chemistry beaker, we mixed two parts of sugar from the mess hall, one part of cocoa from the commissary, and enough water to stir easily. We then placed the beaker for an hour or so in the hot water bath we used to boil urines with Benedict's solution. When time was up, we added vanilla in a Kahn test tube from the syphilis tests to the syrup. Finally, we cooled any chocolate milk or syrup in the refrigerator where we stored the stool specimen cultures. Once our method was known, chocolate pilfering decreased substantially.

In mid-1943, Sector Command informed me one Friday that the following Monday I would receive six medical corps soldiers for four weeks to teach them one third of a course in laboratory techniques. After training, the technicians were to be the sole lab staff of several outlying island posts. Soon, we and two other labs in Port of Spain had a full-scale laboratory technician training program going. I was later made Laboratory Consultant for the Trinidad Sector.

I learned quickly with the aid of textbook illustrations how to identify correctly the luetic treponema and to separate other spirochetes that occasionally were found in dark field preparations. The Kahn test was the only serologic test for syphilis available to our laboratories; we had no other confirmatory tests to rule out false positives. This was the one lab test I always checked personally. Any other grossly abnormal test was checked by me, my lab nurse, or the lab sergeant.

In November I was selected to accompany a tuberculosis patient back to an Army hospital in Miami. (We had an overnight stay in Puerto Rico because we could not enter the U.S. zones after dark.) The Army granted me a bonus 10-day leave, which I used to fly home and see my daughter for the first time. I then flew back to the islands, but by January 1944, Trinidad was being downsized and I was ordered back to the United States. My war service, however, was far from finished.

Ed. note: Dr. De Hoff remained in the U.S. Army Reserves until 1965, when he retired a colonel. Now retired from medical practice, he lives in Baltimore County. ■

TRINIDAD included two endemic centers for malaria: the coastal swamps were breeding grounds for *Anopheles aquasalis* and the highlands, for *A. bellator*. Although *A. bellator* had been suspected as a vector, in July 1941, Dr. Lloyd E. Rozeboom and Mr. Raymound Laird of The Johns Hopkins University found the first naturally infected *bellator* in Trinidad.

Source: West LS. The South Atlantic and Caribbean Areas. In: Coates JB Jr, Hoff EC, Hoff PM, eds. *Medical Department, United States Army. Preventive Medicine in World War II. Communicable Diseases. Malaria.* Vol. VI. Washington, DC: Office of the Surgeon General, Department of the Army; 1963:224.

Lt. Col. Theodore E. Woodward, M.C.

In February 1941, Theodore E. Woodward, M.D., entered the Army Medical Corps as a first lieutenant. He had completed a residency at the University of Maryland Hospital in Baltimore, and only six months of further training at Henry Ford Hospital in Detroit, Michigan. Later, through his experiences, he ultimately developed as a physician and epidemiologist whose work helped reduce the vulnerability of our soldiers to the devastation of tropical diseases.

Lt. Woodward initially was stationed at Fort George G. Meade. After requesting foreign duty, he was assigned to Walter Reed Army Medical School for a one-month course in tropical medicine. He was then assigned to the U.S. Army Engineers in Bermuda, where an epidemic of dengue fever was raging. Based on the techniques he had acquired at Walter Reed, he was able to identify the mosquito vector, *Aedes aegypti.*

He returned to the United States and on December 7, 1941, transferred to Jamaica, British West Indies. There, a medical officer was treating a Jamaican laborer for malaria who failed to respond to intensive quinine therapy. The patient's lack of response indicated to Lt. Woodward that the illness was not malaria. Lt. Woodward sent blood samples to the Walter Reed medical school for analysis. Results showed the patient was suffering from endemic typhus fever, the first such case recognized on the island. Later, because of the threat of typhus, a team of experts went to Jamaica and identified an additional 30 cases.

MARION FRIEDMAN, M.D.

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Woodward TE. Personal interview, August 1995. ■

"DESPITE the relatively high incidence of endemic typhus, the sporadic and unpredictable occurrence of cases generally prevented clinical studies by Medical Department personnel. A few observations were made, however, and which merit record. One of these was an investigation in Jamaica, B.W.I., carried out by Plotz, Woodward, Philip, Bennett, and Evans. Since Jamaica had become a military base for U.S. forces as a result of the lend-lease agreement of 1940, the presence on this island of typhus in any form was a matter of concern to the Medical Department of the Army. The first case of typhus to be recorded in Jamaica was observed by Captain Woodward in December 1941. This study was particularly important in that it proved that endemic typhus was indigenous to Jamaica and had not been introduced by U.S. Army engineer troops in 1941, as had been rumored in some quarters."

From: Zarafanetis CJD. The Typhus Fevers. In: Coates JB Jr, Havens WP JR, eds. *Medical Department, United States Army. Internal Medicine in World War II. Infectious Diseases.* Vol. II. Washington, DC: Office of the Surgeon General, Department of the Army; 1963:208


JAPAN
OKINAWA
MARIANA ISLANDS
Saipan
Guam
PHILIPPINES
Manila
Leyte
Palau Islands
Eniwetok
MARSHALL ISLANDS
Pearl Harbor
HAWAIIAN ISLANDS
GILBERT ISLANDS
NEW GUINEA
Admiralty Islands
Hollandia
SOLOMON ISLANDS
Baugainville
Guadalcanal
Milne Bay
New Caledonia
Fiji
AUSTRALIA
Brisbane
Sydney
Melbaurne
NEW ZEALAND
Auckland

The 18th General Hospital

Marion Friedman, M.D.

. . . . . .

On a cold, rainy April 20, 1942, the members assigned to the 18th General Hospital assembled at Pennsylvania Station in Baltimore in the presence of many teary-eyed relatives and friends. Their destination was Fort Jackson, South Carolina, where in two weeks they were to be fully equipped, inoculated, and indoctrinated. They were then entrained for parts unknown after sending home all cameras, radios, and other personal items that might identify the unit.

Their destination turned out to be San Francisco, where they remained another two weeks. On May 24, they embarked with others via a converted, 14,000-ton luxury liner now known as the *General James Parker*. They were part of a large convoy accompanied by destroyers and cruisers. Near their destination it split and some went directly to the Fiji Islands. The 18th, after traveling nearly 7,000 miles, landed in northern New Zealand on June 24. At the time, the Japanese were massing for an invasion of Fiji, which they could easily have overtaken. Because of faulty intelligence, however, they believed they would have been overwhelmed by a superior, well-fortified force and therefore turned back without any engagement. Members of the 18th were escorted into port by New Zealand naval ships, which sank an enemy submarine that was waiting for them.

The unit was to spend six monotonous weeks in inadequate quarters at Camp Papakura, 19 miles south of Auckland. Although the residents of New Zealand did everything they could to make the Americans feel welcome, with the inactivity and depressing direction the war was taking, the New Zealanders were assuming an impossible task.

The 18th finally was transported, on a vessel named the *President Coolidge*, to the Fiji Islands, known then by the code name *Fan Tan*. The ship had been assigned to return the New Zealanders to their country from Fiji while carrying the Americans back to replace them. The 18th was carried on the ship's third voyage back, the 142nd General Hospital (a University of Maryland unit) having preceded them. They arrived August 3 amid much confusion, with Japanese reconnaissance planes overhead at night and Fiji momentarily anticipating invasion. Plans were to set up a hospital on the northern part of the island, but instead they were told to build their facility where they were. Under these conditions, they were forced to establish themselves in ward huts while a proper site for a 500-bed hospital was located and then built.

At the same time, their task was to prepare for possible patients. Because there were rumors that they might again be moved, they were instructed to un-

pack as little equipment as possible and even to save the packing crates for possible reuse. Many of them became involved in renovating the school, which ultimately was to serve as their hospital. The group affectionately became known as the "18th General Engineers." Later, it was learned that they were expecting to receive casualties from an assault on nearby Guadalcanal. It was necessary to obtain water from a contaminated river two miles away; develop a purification system; construct a reservoir and pressure towers; obtain pumps and generators to provide electricity; find boilers; and build sewers, a disposal system, and a laundry.

The hospital did not receive its first patient until October 22, six months after the unit's activation. The same day, Maj. John R. Hatfield, M.C., who had been assigned to the 18th as its executive officer, died of a coronary thrombosis at a station hospital (his unit was not yet ready to receive this type of patient).

When the hospital first began admitting patients on Fiji, there were only 56 beds ready for immediate use. Much of the radiographic and other equipment had not even been unpacked because, as noted earlier, it was being held in readiness for another possible move. Nevertheless, casualties began pouring in. To accommodate them, ward tents were pitched, prefabricated buildings began being erected, and concrete was poured directly on the grass to make walks so that litters could be moved. Much of the work was done by the medical officers. Five days after they received their first patient, a naval hospital ship brought in 324 casualties, mostly Marines, from Tulagi and Guadalcanal. Within three days, they increased the capacity of the hospital fivefold.

Although medical patients outnumbered surgical patients by about two to one, mostly suffering from malnutrition, malaria, jaundice, and psychoneurosis, there were blast injuries, compound fractures, and severe comminuted fractures resulting from torpedoed ships. When it became obvious that the medi-

Capt. Philip A. Tumulty, Capt. (later Major) Edward Nichols, Maj. (later Lt. Col.) Martin L. Singewald, and Maj. Lidz selected for complete physical and psychologic study 50 men who had suffered 10 or more attacks of malaria. "This comprehensive investigation gave confidence to men in the area responsible for malaria policies by demonstrating that no measurable organic damage or dysfunction resulted from the weight loss and debility that were almost a constant sequel to chronic malaria. These symptoms seemed more related to the way individuals adjusted to chronic malaria and to concurrent situational factors than to the effects of the malaria alone" (Tumulty PA, Nichols E, Singewald ML, Lidz T. An investigation of the effects of recurrent malaria: organic and psychological analysis of 50 soldiers. *Medicine* 1946;25:17-75).

From: Baker BM. South Pacific Area. In: Coates JB Jr, Havens WP Jr, eds. *Medical Department, United States Army. Activities of Medical Consultants.* Vol. 1. Washington, DC: Office of the Surgeon General, Department of the Army; 1961:612.

Tuesday, September 28, 1943

"Spent the day at the 18th General Hospital–a grand crowd. . . . They need masks, bladders for the anesthesia machine, intratracheal anesthesia sets. They have five National field sterilizers we can have, and an extra 230 kv. electric sterilizer. They also have horizontal autoclaves, utensil sterilizers, and hot water sterilizers–all of them run on steam. The supply unit is well equipped."

From the diary of Col. Ashley W. Oughterson, M.C., surgical consultant in every major command in the Pacific theater.

Source: Coates JB Jr, Carter BN, McFetridge EM, eds. *Medical Department, United States Army. Surgery in World War II. Activities of Surgical Consultants.* Vol. II. Washington, DC: Office of the Surgeon General; 1964:798.



Surgical ward of the 18th General Hospital on the Ledo Road near Assam.
Reprinted from *Medical Department, United States Army. Surgery in World War II. Activities of Surgical Consultants.* Vol. II. Washington, DC: Office of the Surgeon General, Department of the Army; 1964:940.

cal officers would be needed on Fiji for some time, more equipment was made available and soon they had most of the things they needed.

Malaria was the big threat to incapacitate large numbers of U.S. troops, and Lt. Col. Benjamin Baker of Baltimore, chief of the medical service, began to study it. At the time, quinine was almost completely unavailable and Atabrine was a new, untested drug—dosage, frequency of administration, and toxicity were unknown. Although it was poorly accepted by the troops, Atabrine did reduce the rate of malarial infection if ingested regularly. About that time, a physician of the unit, Capt. Roger A. Lewis of Bethesda, perfected a method of determining the amount of Atabrine present in the human system that was sensitive enough to be used in a hospital laboratory and later in the field. It could detect one part of Atabrine in 100 million parts of blood serum. It was valuable in determining toxicity, levels needed for effective therapy, and whether or not a soldier was actually taking the drug. When Lt. Col. Baker was promoted, Lt. Col. Alexander J. Schaffer assumed directorship of the malaria study. Although the 18th was not alone in its medical battle with malaria, it played an important role.

The 18th General Hospital experienced a change in command just before Christmas, when Lt. Col. Amos Koontz was ordered to New Zealand and Lt. Col. George Finney assumed command.

About one year after the hospital opened, it reached its peak of 1,043 patients. Because of the hundreds of cases of malaria treated at the installation, it also engaged in much research in this field. As the war moved further north, the census of the hospital on Fiji diminished. Col. Finney was awarded the Legion of Merit and was transferred in June 1944, at which time he was replaced by Lt. Col. Richard W. Graham. On August 1, 1944, the hospital was closed and its 40 remaining patients transferred. During its 22 months of operation, it admitted 12,195 patients.

On September 16, orders were received for removal of the unit to India. The University of Maryland 142nd General Hospital, also on Fiji, received similar orders. The two units, each of which by that time had been enlarged to 1,000-bed facilities, were transferred with all their equipment. The move was uneventful. It included a three-day stop at Melbourne, Australia, with a two-day

Physicians' ingenuity under trying conditions was nothing short of remarkable. Capt. Lewis devised a basal metabolism machine from a gas mask, tin cans, bits of glass, odd pieces of rubber tubing, and a pulley. Fracture boards were devised from packing cases and anesthetists' bags from old football bladders.

shore leave—the first time in almost two years that the personnel had the opportunity to visit a big city and partake of the amenities it could offer them.

When the men arrived at filthy, scum-covered, oily Bombay harbor, the two units separated. They were to be advised of their exact destinations later. Because booster inoculations against typhoid, typhus, smallpox, and cholera were required in this area every six months, they were immunized and then divided into four groups to be taken across India by train. Most of the cars were "third class," with wooden slat benches and similar ones overhead that could be lowered at night to provide berths. All plumbing had been removed from the cars—the only toilet was a hole in the floor. At night, the only light was a closely guarded, dim bulb at each end of the car; all the others had been removed. Window glass was often broken and without screens (the trip fortunately was being made during the nonmalarial season). Food consisted of C and K rations. There was little water; the only time there was any for bathing was during the approximately three times a day the train stopped to change crews and for repairs and for watering the trains themselves. A portion of the trip consisted of a four-day voyage on a primitive river boat where the troops occupied the upper deck, sleeping in relays on the deck, which they shared with rats, mice, and colossal roaches. They then boarded an even more ancient and dilapidated, narrow-gauge train for the final journey. The entire trip from Bombay took 12 full days.

"We saw a newsreel of George Finney and Mrs. Roosevelt charging up a hill to inspect Gen. Hosp. 18 out on a S. Pacific isle. He looked leaner but fine. There was a blur of other officers in the background, but it all went by too fast to distinguish any—we were disappointed."

Caroline Bedell Thomas, M.D., in a letter to Col. Henry M. Thomas, Jr., M.C., dated Monday, September 27, 1943.

On October 26, 1944, the 18th General Hospital took over the operation of a 450-bed hospital on the Ledo Road near Assam. They were the third organization to operate it, the first having been a unit affiliated with the University of Pennsylvania. When first used, it had been well supplied and crowded with casualties. Because the Japanese were withdrawing troops from this area to bolster their defense of the Philippines and their home islands and because other hospital units were also being assigned to this general area, the outlook was bleak for much activity for the 18th. Very few of the patients they served were battle casualties. Even their own officers and nurses could not be treated at their hospital when taken sick because the base surgeon refused to allow the opening of an officers' ward. In February 1945, Maj. Gen. Frank Merrill visited the

IN MEMORIAM

Martin L. Singewald, M.D., an internist who retired from the practice of medicine in 1986, died of circulatory disease September 15, 1995, at Charlestown Retirement Community in Baltimore. Commissioned a major with the U.S. Army for service with Hopkins' 18th General Hospital, Dr. Singewald was later promoted to lieutenant colonel. He was the unit's sanitary officer in the Fiji Islands, an enormous responsibility. R. Carmichael Tilghman, M.D., Dr. Singewald's long-time friend and fellow veteran of the 18th General Hospital, said, "Whatever was turned over to [Dr. Singewald] would be done and done to perfection. He was so careful professionally, so excellent." Dr. Tilghman said Dr. Singewald worked constantly while they were in the Pacific, in part to assuage his homesickness, in part because of his desire to help others. "He was always doing something for someone else," said Dr. Tilghman. "He was one of the most compassionate men I have every known." Dr. Singewald's military career also included service as chief of medicine at an Army hospital at Fort Storey, Virginia.

Born in Baltimore, Dr. Singewald earned his medical degree at The Johns Hopkins University School of Medicine in 1938. After serving internships in Baltimore (at City Hospitals) and Cooperstown, New York, he returned to Hopkins for his residency training. In addition to his private practice, Dr. Singewald was an associate professor of medicine at Hopkins. He had staff privileges at Greater Baltimore Medical Center and Church, Good Samaritan, Hopkins, and Union Memorial hospitals. A fellow of the American College of Physicians and Surgeons, he was a former president of both the Johns Hopkins University Alumni Association and the Maryland Hospital Service. Dr. Singewald was 86. ■

area and ordered them into a new base at Myitkyina, Burma, where they were just starting to build a 1,000-bed hospital. He also ordered that they could begin a rotation in which they could return home or, after a leave, return to the base. With the lessened need for their services, most elected to leave; by March 22, all of the original members of the Hopkins unit had departed, although the unit was not officially deactivated until October.

For almost three years, however, the 18th had essentially been a Johns Hopkins unit. It had been one of the first general hospitals in the Pacific and had received casualties from the Solomon Islands, the first American offensive in World War II. Although the remainder of their service was in less demanding areas, their patriotism and valor were never in question. They served at the orders of those in command and were ever ready to contribute of themselves whatever was demanded. Despite periods of less than optimal activity, the 18th General Hospital during its tenure in the Pacific cared for more than 13,000 patients.

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Tilghman RC. Personal interview, August 14, 1995.

Ed. note: *Lt. Col. R. Carmichael Tilghman, M.D., executive officer and chief of medicine, was appointed official historian of the 18th General Hospital. He is a retired internist living in Baltimore County.* ■

Physicians of U.S. Army General Hospital 18

Commanding officers
- Lt. Col. Amos R. Koontz (later colonel)*
- Lt. Col. Richard W. (Walter) Graham
- Lt. Col. Winford Smith

Chiefs of medicine
- Lt. Col. Benjamin M. Baker (later colonel)**
- Maj. Richard C. (Carmichael) Tilghman (later lieutenant colonel)
- Maj. Alexander J. Schaffer (later lieutenant colonel)

Chiefs of surgery
- Lt. Col. George G. Finney (later colonel)***
- Maj. Richard T. Shackelford (Med Chi secretary, 1942)
- Maj. Ralph G. Hiller

Other personnel
- Maj. Dudley C. Babb
- Maj. Adam C. Bock
- Maj. Webster H. Brown
- Maj. H. Alvin Jones
- Capt. C. Bernard Brack
- Capt. Walter B. Buck
- Capt. Edmund B. Kelly
- Capt. Theodore Lidz
- Capt. Mitchell H. Miller
- Capt. Edward Nichols
- Capt. M. (Martin) Louis Singewald
- Capt. Edward S. Stafford
- Capt. Douglas H. Stone
- Capt. Hayward B. (Baldwin) Streett
- Capt. Charles B. Troland
- Capt. William S. Watson
- Capt. M. Richard Whitchill
- Lt. Robert C. Austrian
- Lt. William G. Beadenkopf
- Lt. Paul Higgins
- Lt. James E.T. Hopkins
- Lt. Frank W. Kibbe
- Lt. Gustav Kruger
- Lt. Roger A. Lewis (later captain)
- Lt. Max Michael
- Lt. Robert L. Payne, Jr.
- Lt. William C. Quinby, Jr.
- Lt. Phillip A. Tumulty

* *Dr. Koontz became a consultant to the Surgeon for the U.S. Forces in New Zealand and later, a consultant to the Chief Surgeon of U.S. Forces in the South Pacific. He was awarded the Bronze Star and the Army Commendation Ribbon with Oak Leaf Cluster.*

** *Dr. Baker became medical consultant for the South Pacific. He was awarded the Legion of Merit.*

****Dr. Finney became surgical consultant for the 10th Army. He was awarded the Legion of Merit.*

"DR. WILLIAM Houston Toulson, professor of genitourinary surgery, University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore, was chosen secretary of the Medical and Chirurgical Faculty of Maryland at the annual meeting, April 28-29, to fill the unexpired term of Dr. Richard T. Shackelford, Baltimore, who has entered army service. Dr. Robert Lee Hall, Pocomoke City, is president. It was also decided to cancel the semiannual meeting of the society, usually held in the early fall."

JAMA 1942;119:507.

Colonel Benjamin M. Baker, M.C.

Called to active duty early in 1942, along with other Hopkins physicians who had volunteered for its general hospital, Benjamin M. Baker, M.D., had been at Hopkins since 1925. He was chief resident in medicine there in 1930, and when the Japanese bombed Pearl Harbor, had been running Hopkins' outpatient department for 11 years. Like so many men, he left behind his wife and infant daughter to serve his country.

As chief of the medical service for the 18th General Hospital, Dr. Baker's primary acitivity on Fiji was investigating the overwhelming incidence of malaria in the Solomon Islands (there was no malaria on Fiji), where one of the worst malarial outbreaks in history occurred during World War II. Because the Japanese had cornered almost all available supplies of quinine, then the treatment of choice for malaria, Atabrine was used instead to suppress its symptoms. Although it was often extremely difficult to convince military personnel to take Atabrine (active malaria meant a respite from combat; Atabrine also turned people yellow), Dr. Baker took an Atabrine tablet every day for three and a half years.

Dr. Baker saw combat on Guadalcanal and Bougainville ("on Bougainville, the Japanese were right behind us; it was a madhouse"), where he and his fellow physicians strove to provide Hopkins' standards of medical care—in tents. The medical units took their supplies with them; surgery was performed during combat. Drug supplies were ample, but there was no blood and the physicians had to recruit donors for the wounded.

After Bougainville was secured, Dr. Baker was promoted to full colonel and awarded the Legion of Merit for his work on malaria control and medical care in the combat zone. He was then appointed a consultant in medicine to the U.S. forces in the South Pacific and moved to New Caledonia, serving on the staff of Brig. Gen. Earl Maxwell, M.D. He also served as a consultant for the western Pacific in preparation for the battles on Iwo Jima and Okinawa.

Before the U.S. landing on Okinawa, Dr. Baker obtained the first whole blood that was available in the Pacific. With 1,000 pints of whole blood, he got on a flying boat headed for an island about 20 miles from Okinawa. Landing on Okinawa about two hours after the first troops, he set up a small station hospital tent. Casualties ran high; every available physician "who could cut was made to cut." Dr. Baker taught "a bootlegger, a barber, and a cab driver" how to give blood transfusions.

When the fighting on Okinawa lessened after about a month, Dr. Baker went to Guam expecting to be sent home. Instead, he received orders from General Douglas MacArthur to report to Manila for duty as MacArthur's consultant in medicine for the expected invasion of Japan. MacArthur picked 20 officers in his command, one of whom was Dr. Baker, to go to Washington, D.C., to brief Army commanders about the differences between the war in Europe and the war in the Pacific (lack of fixed medical facilities with island warfare; lack of supplies when and where needed; lack of personnel; malaria). While Dr. Baker was in Washington, the atomic bombs were dropped on Hiroshima and Nagasaki. Still under orders, Dr. Baker returned to Manila where he began briefing senior medical officers on the expected medical situation in Japan.

After the war, Dr. Baker returned to Hopkins, where he became a professor of internal medicine and pursued research interests in atherosclerosis and colon cancer. He retired from private practice at age 65 and lives in Baltimore County.

Mary Ann Ayd

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Both physicians and patients were subjected to strange and unfamiliar conditions which influenced the practice of medicine in the South Pacific. In civilian practice, doctors learn that one diagnosis generally suffices to explain clinical problems. In the Pacific, the reverse was true. More often than not symptoms indicated a combination of diseases. Many medical officers failed to give adequate attention to the probability that more than one diagnosis was necessary to fit together such groups of symptoms.

Malaria was the most common partner in such compound diseases. Often, an acute respiratory infection, an attack of dysentery, or a surgical condition reactivated latent malaria and led to confusion in diagnosis. Such perplexities were most common early in the war when it was not generally realized that repeated search for malaria parasites in all febrile conditions was a necessary diagnostic precaution.

Observers who possessed training in trustworthy laboratory techniques were not numerous at the time. Gradually, as more experience was acquired by hospital staffs and the great frequency of malaria became apparent, the disease was more universally suspected. As time passed, reliable measures to exclude it as a contributing factor in difficult diagnostic problems were more commonly and efficiently employed.

Both dengue and infectious hepatitis were frequently accompanied by malaria. Hepatitis caused particular concern because textbook descriptions of jaundice in malaria and a constant fear of the hepatotoxic effect of Atabrine combined to confuse medical officers in the proper interpretation of jaundice. The treatment of hepatitis by antimalarial drugs was rarely if ever harmful to patients, but fear of the significance of jaundice added to the general confusion surrounding the treatment and suppression of malaria.

The combination of eosinophilia, light hookworm infestation, and any one of a variety of common medical conditions in a single patient was often encountered among combat troops. This resulted in confusion in the interpretation of vague symptoms, and many patients were treated for hookworm disease when their symptoms were caused by something else. The difficulty of demonstrating hookworm ova in light infestations and the stubborn response to therapy led to further diagnostic difficulty.

"Disease awareness," a diagnostic pitfall whenever disease occurs in epidemic proportions, was common in the Pacific. This awareness is a good guide to diagnosis, but it can lead to serious errors when followed too far. Common diarrheas were so universal soon after the landings on nearly all islands that carriers of bacillary dysentery were often unwittingly discharged to duty and many cases of amebiasis were overlooked because adequate laboratory facilities were lacking. Most febrile diseases were quickly called malaria without laboratory confirmation and were treated as such. This caused considerable harm to the patient in those cases when wounds of the head, cerebral hemorrhage, or meningitis were treated as cerebral malaria. The reverse was also the case, as examples were discovered proving that death from cerebral malaria too often resulted after a faulty diagnosis which delayed the use of antimalaria therapy until it was too late.

From: Baker BM. South Pacific Area. In: Coates JB Jr, Havens WP Jr, eds. *Medical Department, United States Army. Internal Medicine in World War II. Activities of Medical Consultants.* Vol. 1. Washington, DC: Office of the Surgeon General, Department of the Army; 1961:593-595.

"WHOLE blood is shipped successfully across the Pacific by air in an insulated container in which the bottled blood is placed in racks around a large compartment of cracked ice, according to Charles F. Belshaw, research consultant of the National Association of Ice Industries. He explained that although temperatures inside planes in the Pacific often go as high as 130 F., this method keeps the blood to be used in treating the wounded at a temperature between 40 and 45 F., which is necessary to keep it in usable condition."

JAMA 1945;128:888.

LT Everard F. Cox

The son of a dentist, Everard Cox grew up in St. George, Utah, a small community about 100 miles from Las Vegas. He had completed two years of college when he enlisted in the naval aviation V5 program in 1941. Called to active duty December 4, he was in Oakland, California, across the bay from San Francisco, on December 7. That Sunday, panic seized the West Coast. Every time a light was glimpsed out on the Pacific, all lights on land were extinguished and "absolute chaos" ensued. At the naval base, the men were told to muster in the hangar. A marine sergeant asked if anyone present had ever shot a rifle. Seaman Cox and a few others stepped forward, were handed rifles, and were ordered to patrol the base perimeter until relieved. If anyone approached, they were to shout "Halt" three times and if not obeyed, shoot to kill. Seaman Cox patrolled the fence from 3:00 that afternoon until he was relieved the following the morning. No one was shot.

From Oakland, he was sent to Dallas, Texas, then to Corpus Christi for flight training as an aviation cadet. In August 1942, he was commissioned an ensign. He received advanced fleet training on carrier-type aircraft in Miami, Florida, and finally, with the Air Group 12 Bombing Squadron in San Diego, California, trained in the Douglas dive bomber, "the most important aircraft in the Pacific during World War II—it won the Coral Sea and Midway." In May 1943, then-LT Cox boarded the carrier *Enterprise*. A month or so later at New Caledonia, he boarded the *Saratoga*, the carrier he would call home for the next 16 months.

A battleship hull converted to a carrier, the *Saratoga* was 1,000 feet long, could carry 96 aircraft. It operated independently of the task force because its size limited its maneuverability. Among its most significant battle engagements was the provision of air power during the Allied landings at Empress Augusta Bay on Bougainville beginning November 1, 1943.

The U.S. naval fleet had expended essentially all its ammunition bombarding the shore to cover the Marines' landing. Once ashore, however,

The President of the United States takes pleasure in presenting the
DISTINGUISHED FLYING CROSS to

LIEUTENANT EVERARD FRANCIS COX
UNITED STATES NAVAL RESERVE

for service as set forth in the following
CITATION:

"For heroism and extraordinary achievement in aerial flight as Pilot of a Dive Bomber in Bombing Squadron TWELVE, attached to the U.S.S. SARATOGA, during action against enemy Japanese forces in the strongly fortified harbor at Rabaul, New Britain, on November 5, 1943. Courageously approaching the target in the face of intense antiaircraft fire from numerous hostile warships and shore batteries, Lieutenant (then Lieutenant, Junior Grade,) Cox engaged an intercepting enemy fighter plane in vigorous combat and succeeded in blasting the aircraft from the sky. Skillfully maneuvering his bomber for maximum striking power, he pressed home an effective assault upon a hostile heavy cruiser despite persistent enemy aerial opposition. Forced to fly through concentrated crossfire between the Japanese vessels upon retirement, he successfully warded off an attack by a group of hostile fighter planes. Lieutenant Cox's airmanship and devotion to duty in the face of grave peril were in keeping with the highest standards of the United States Naval Reserve."

For the President,
[signed] James Forrestal
Secretary of the Navy

the Marines were unprotected. A nearby Japanese armada and airstrips on the other side of the island posed a severe threat. With the *Saratoga* the only U.S. carrier then in the area, the pilots' mission was to cripple the Japanese planes and ships. "Naval intelligence was remarkable. During our predawn attack on the airstrips, we went in knowing what to expect, the exact layout of the target."

On November 3 and 4, the *Saratoga* sailed around the southern tip of Bougainville to launch an attack on Rabaul on November 5. During the battle, the carrier was beyond the range of its own aircraft—had anything happened to it, the aviators would have had no choice but to "go in the drink." They didn't. The Japanese fleet never left the harbor. The Americans lost 23 pilots and flight crew members during that raid.

From August to November 1943, the Saratoga *was the only U.S. carrier in the South Pacific. It played hide and seek with the Japanese, not only to avoid being sunk, but to give the illusion that it was not the only carrier.*

Of the nine battle stars on LT Cox's Asiatic Pacific ribbon, eight were awarded for his participation in campaigns in the Solomons, in the Marshalls, in the Gilberts. In the Marshalls, he flew over Eniwetok for nine straight days, using a grid map "to systematically bomb every square inch." In the Gilberts, he and his fellow pilots ran dozens of missions over Tarawa to cover the Marine landings there. The ninth star on his ribbon, however, the one for the raid on Rabaul, was designated a battle star in its own right by the War Department. LT Cox's career as a naval aviator included more than 300 carrier landings with not so much as a scratch to his plane or the carrier. In addition to the distinguished flying cross (for which he was recommended by Vice-Admiral William Halsey), he was awarded the air medal, and an admiral's citation.

There was a price. Of the 16 men in his initial group who completed flight training, only two were alive at the end of the war. Among his most profound memories are the burials at sea. After every raid there was a full ceremony: chaplains, gun salute, taps, the shrouded body tipped up, sliding quietly to its grave. "Wars are fought by the young. No, you don't get used to it."

Following the battles in the Marshall Islands, the *Saratoga* became part of Lord Louis Mountbatten's fleet in the Indian Ocean, whose task it was to open a second front to hold Japanese forces in that area while the Americans prepared to attack the Marianas and Iwo Jima. Mountbatten's fleet included British, French, Dutch, and U.S. ships and after Italy surrendered, two Italian destroyers. When LT Cox was detached from her, the *Saratoga* had been at sea so long she was sent to dry dock in Bremerton, Washington.

LT Cox had left Utah "a shy young boy without much chance to excel." He returned a mature young man who knew what he wanted. He finished college and, with the newly granted education benefits of the G.I. bill, applied to, and was accepted at, the medical schools at Columbia and the University of Maryland. He chose Maryland. Following an internship with the Navy, recruiters tried to entice him into a "special project," the nature of which they refused to disclose. Had he known it was the astronaut program, he probably would have taken it. He chose a surgical residency at the University of Maryland Hospital in Baltimore.

During the summer of 1945, LT Cox participated in what turned out to be the last U.S. war bonds tour. At Birmingham, Alabama, it was estimated that a crowd of 200,000 people turned out. "There was so much lipstick on our plane from girls kissing it, we had to wash it before we could take off."

Dr. Cox's medical career was in academic surgery in several states. He was an associate professor of surgery at University of Maryland Medical Center and chief of surgery at Maryland as well as Shock Trauma. Now retired, he lives in Baltimore County with his high school sweetheart, whom he married after he completed flight training. They run five miles each morning.

MARY ANN AYD

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PACIFIC MEMORIES



Mobile Hospital No. 8, which arrived on Guadalcanal in April 1943. It was commissioned August 1943 and designated as Fleet Hospital No. 108 in 1944. By December 1944, MOB 8 had treated 39,395 patients. Reprinted from: McIntire RT, Avery BF, eds. *The History of the Medical Department of the United States Navy in World War II.* Washington, DC: United States Government Printing Office; 1953:21.

LT CMDR Jonathan M. Williams, MC

I went to Guadalcanal with "Mob 8," a naval hospital. We doctors and corpsman built the hospital there. I mean *we* built it, including hospital wards of Quonset huts, sewers, roads, tents—everything. Although ground action by the Japanese had largely stopped, we were harassed by "Washing Machine Charley," a slow-moving night bomber that spread 50- and 100-pound bombs indiscriminately and then fled. Once in a while our Navy fighters would challenge him. It was a small Fourth of July for us as we lay on the ground by our foxholes and watched the lazy stream of tracer bullets creep across the sky to waver, then hit "Charley." How we cheered as his flaming remnants dropped through the darkness to burn to cinders and disappear into the night.

That was Guadalcanal, the island, the solid land. But there was another Guadalcanal. It was the whole Solomons, those many islands, large and small, beautiful, strange and threatening, that we called *Guadal* or simply *the Canal.*

On Guadalcanal, our work days were long and relief time short. On occasion, however, as the war lagged, we had a Sunday's half day off.

On one of those Sundays in May 1943, Dr. John Timothy Kane and I caught a ride to Tulagi on an APC—an "Appleseed" we called it—that ran the 25-mile stretch between Lunga and Tulagi. Once on Tulagi, J.T. and I separated. I went to visit the Anglican bishop of the Solomons. Amid a slew of small native children, I learned that these youngsters had been saved by the bishop. They were the survivors of twin births, and this priest had salvaged them from the island's practice of killing and eating the "other child." Food from the forests, the sea, and the natives' primitive gardens was insufficient to feed an unexpected extra mouth.

It was a tranquil afternoon, sipping tea and watching the youngsters romp.

All too soon, it was 1700 hours, and J.T. and I had missed the APC back to the Canal! J.T. had been looking for his brother and had found him attached as an officer to a squadron of PT boats based in a small inlet on Tulagi. Brotherhood and Irish came together at that moment. In the officers' quarters of the unit, JT and his brother asked a favor of a trip back to the Canal.

"I'll crank up and take you both back," volunteered a young lieutenant named Kennedy.

And so we got our only ride on a PT boat. Was it noisy! And rough and fast! Three Packard 12-cylinder engines and four deck-mounted torpedo tubes and no place to hang on to when under way. We got back to Lunga in record time, but it was such an ear-splitting ride I never heard the captain's full name, and I'm sure he never heard mine.

Ed. Note: In April 1943, LT John F. Kennedy was sent to PT-boat Squardron 2 on Tulagi. Later that same month, he served on PT-109. In May, he was patrolling the Pacific. PT-109 was rammed August 2, 1943, by a Japanese destroyer.

Source: Hamilton N. *J.F.K.: Reckless Yourth,* New York, NY: Random House; 1994.

I shipped off from Tulagi in the summer of 1943 on the USS *McKean*, APD 5. She was a World War I "fourpiper," a destroyer of the kind Roosevelt gave to Britain at the start of World War II. In the Pacific, they were throwaway vessels to challenge and annoy the Japanese, not expected to win anything. They were gnats.

The two forward boilers had been removed to make room for troop space. Her flank speed was 27 knots. Our duty was to glide in at night where the ground action was, drop off fresh Marines, and pick up wounded to take them back to the naval hospital that I had left earlier. At other times, we ran escort to convoys making newer landings.

It was on such duty that the *McKean* was lost. We were sailing north to Bougainville at night, with the convoy being circled by marauding Japanese torpedo bombers—"Kates," I believe. We could see them against the night sky.

"Don't fire on them unless they turn in on us to make a run," the captain ordered.

At 0217 on November 17, one of them did just that.

It came at us from the starboard quarter and dropped its "fish." I was on the flying bridge and could see the white trail of bubbles approaching. The captain ordered a hard left rudder and flank speed to present the minimum target. But it was too late. We were hit in our after quarter fuel tanks, which exploded and burned. The davits holding the life boats melted in the heat, dropping the boats into the sea. There were burning drops of oil like fiery tears running slowly down the walls of the wheelhouse. A skirt of burning oil was trailed by the *McKean*. The "battle stations" whistle started shrieking.

We were still under way from our momentum, and I was horrified to see Marines, in panic, jump into the water, only to be swept into the flames that we were still spewing. One or two cork-and-lattice life rafts remained and were lowered into the water. I had heard the hard-to-believe story that those abandoning ship usually take their shoes off before jumping, and as I looked at the foredeck, I saw a row of shoes neatly lined up along the edge. When, as far as I could tell, all survivors had left the ship, the captain and I stood amidships, shook hands, and

12 August 1944
From: Lt. H.W. Bruskewitz, (MC) USNR
Lt. J.H. Williams (MC) USNR
To: The Corps Surgeon, II Amphibious Corps
Subject: A Report on the Medical and Sanitation Conditions at Camp Mennengon (A Native Camp Operated by Civil Affairs)

1. The below report is submitted for your information:

Camp Mennengon is a temporary camp erected by the Japanese to concentrate groups of Chamorro natives when the shelling and bombing of the island [Guam] by our forces began. It is situated on the Ylig River, about 1½ miles from the mouth.

A concrete road passes within one mile (more or less) of the camp but access to the camp is only by foot or bullock cart. All food and equipment not easily carried is transported over an exceedingly rough trail in two-wheel carts drawn by carabao. Patients to be brought out are carried by teams of stretcher bearers, high on the shoulders. The camp itself extends over perhaps 50 acres on both sides of the sluggish muddy Ylig River. It is flat flood land and has a water table about 18-20" below the surface. In this area live upwards of 6,000 Chamorros with their carabao, cattle, goats, and chickens. The authorities have made an effort to keep the stock away from the living quarters, but this is a difficult thing to do as these people are much attached to their animals.

Scattered over this 50 acres are many small huts made of woven coconut fronds. They are floored by woven matting or palm fronds but the dampness and muck oozes through anyway. Some people have "cobbled" their homes with coconut husks and over these they spread their matting. They sleep on the floor. At one end a fire is kept going for cooking purposes and consequently the hut is usually smoke filled. One such place visited was about 8' x 18' and housed 21 persons. Young and old, sick and well, all are crowded into this squalid place.

Upon our first arriving at this area, the people were found crowded onto the highway and on their way to Agat and Agaña and had to be turned back to the camp area. The scene, with these thousands of ill and malnourished people and their livestock and belongings presented an almost hopeless picture. We started transporting our food and medical supplies up the trail by back when two Japanese soldiers were encountered and one was shot. Our men dropped the supplies and scattered. The natives later remade their way up the trail and pilfered the food and destroyed the medical supplies, thinking they were Japanese. Fortunately LST 71 was sighted offshore and was signaled to send in a Higgins boat. By boat, two loads of the more extremely ill patients were evacuated and the barest of essential medical supplies to do first aid and treat diarrhea and pneumonia were obtained. One small marantic baby died before the camp was reached and was buried by the roadside.

The campsite was reached at night. The following morning the dead Japanese who had been killed and two patients who died during the night were buried. During the first 48 hours five people died and were quickly buried. Hundreds were given medical care. Six Japanese were captured during this period around the camp area. During the first days there were no means whatsoever to evacuate the sick and proper food or milk was unavailable, neither were there nearly enough huts to house the people. Our meager supply of medicines exhausted themselves in a few days. The first day drinking and cooking water for the camp was located nearby. It is piped through bamboo to river's edge. The true source of this water was not found but probably originates at springs. Despite this, the water becomes polluted and must be boiled. Erection was begun on large thatch and bamboo huts to form a commissary. Slit trenches were also started under the supervision of Dr. Sablon. Dr. Bruskewitz was taken ill with dengue at this time and returned to this station.

continued on next page

On the second day following Dr. Bruskewitz's return from Mennengon, I went up with Captain Kraus and some medical supplies, most of which Dr. Bruskewitz had found were sorely needed. Beside the usual assortment of dressings we included plasma, vermifuges, sulfa ointments and sulfur ointments, diarrhea mixtures (B1 and paregoric) and sulfathiazole in tablet form. I also took a meager supply of instruments, sufficient to open abscesses, and a stethoscope.

I met Dr. Ramon Y. Sablon (University of Louisville 1938), a Chamorro himself who has struggled valiantly against great odds to maintain his people's health. His presence in the camp is most fortunate as he commands great respect among the natives and is, I believe a capable physician. Dr. Sablon had already been instructed and undertaken measures to keep the water supply pure, and repeatedly told the people to keep boiling their water 15 minutes before drinking it. He said sadly, however, that he thought many were not doing this. He also had been instructed in and had constructed 15-20 small straddle trenches for family groups to use. In this he was more successful although it was hard to get across the idea that the excreta must be covered with earth after being passed. When I arrived there was approximately 30 Marine personnel living in the camp. These were members of patrols, MPs, one or two corpsmen and the Civil Affairs Officers. Living conditions were definitely inadequate but on the day following my arrival, a very satisfactory native barracks was built with a raised platform upon which all the men might sleep. With a nearby straddle trench which is burned out daily, with all their water boiled and their rations inspected, I consider that these men are living in satisfactory quarters and under adequate hygienic field conditions. For the three days I was in the camp the men all had fresh meat. This was unfortunately due to someone unknown hamstringing some native cattle which necessitated their butchering. Both Dr. Sablon and I inspected the meat and passed it as edible. The meat itself was tough but good. Dr. Sablon informs me that there is no bovine Tbc on Guam but liver-flukes are not uncommon so I ordered that no organs (pancreas, kidneys, thymus, liver, etc.) be eaten. So much for our troops.

The problem of native medicine is primarily one of malnutrition with its concomitant increase in tuberculosis, infestations and lowered bodily resistance. A huge proportion of the population suffer from active tuberculosis, I would estimate between 30-50%. About 95% of the population have worms. *Asceris Lumbricoides* is the most common though *Oxyuris* (pinworm) and hookwork is also prevalent. Dr. Sablon showed me infants where he might see the worms moving like irregular parastalic waves on the abdomen. These small children, underfed to begin with, are further sapped of their due nourishment by these infestations until children of 2-3 years of age look like 1-month-old babies. Many have a nutritional edema of the hands and feet and the flabby protuberant abdomen commonly seen in starvation. I will cite in slight detail one of these cases which I treated. There was brought to me a cachectic female by her mother. I frankly thought the child had died when I first glanced at it. The child appeared to be 12-14 months old. I was thunderstruck when the mother told me she was four years old. She was utterly listless. I prepared and gave her intravenously 100 cc of plasma and during the operation the child started to cry with a breathless, thin, little voice. The mother was overjoyed for, as she told us, that was the first sound the child had uttered in over a month. I cite the above which is admittedly extreme, but does indicate the medical state of approximately 40% of the pediatric population. In spite of Dr. Sablon's warnings many people have diarrhea with both mucus and blood. We believe it to be bacillary. Bismuth and paregoric was prescribed for all as long as the supply lasted and also sulfathiazole (diazine) gms 2.0 Stat, then gms 1.0 q4h x 5. It was gratifying how well these people respond to chemotherapy. I treated three cases of lobar pneumonia with sulfadiazine and left all three on the road to recovery in spite of the inadequate housing and nonexistent nursing facilities.

Obstetrics is done by nurses trained by the staff of the US Naval Hospital. They rendered adequate help, by and large, but are called in late and have little or no equipment. Yaws is prevalent. I referred to the hospital some dozen cases with widespread skin lesions–both children and adults. I was told by a nurse that there is a case of leprosy somewhere around but I did not see her. The nurse told me that she (the patient) was already booked for the leprosarium in the Philippines when the Japanese invaded Guam and that nothing was done about her then. Just before I left a hospital was being erected by the natives where the sick could

be segregated and some form of systematic treatment be instituted. For infants it is planned to use the large tent-like mosquito nets abandoned by the Japanese as a measure to prevent cross and reinfection by flies.

The fly problem of Mennengon is almost beyond description. Never in all my life have I ever seen so many flies. They are so thick they swarm like bees and attack a piece of refuse (or any open wound) in layers as much as half an inch thick. While holding my sick call I had two small boys whose only job was to keep the flies off me and the patients. Since a large proportion of the population is barefooted, hookworm is prevalent and profound anemias resulting from this are not uncommonly seen. The problem has a solution.

Finally, the area of the camp is in more or less neutral territory and Japanese are not uncommon. The day before I left 6 were killed by native or marine patrols and one brought in wounded. This man, Ota Sabaru, claimed to have been a laborer in the Navy. I treated him for a through and through gunshot wound of the right shoulder and fracture of the skull. He died during the night. His burial was prompt the next morning.

Conclusions

1. Dr. Sablon should be given all medical equipment necessary for his needs as he is preeminently qualified in the practice of medicine among Chamorros.
2. The pediatric problems of malnutrition and infestations as well as bacillary diarrhea are the most pressing of all. This will require canned or powdered milk in abundance, vermifuges, diarrhea potions, and parenteral fluids including plasma.
3. The sanitation of the camp is only temporarily adequate. If this camp is to continue some planned sanitation project must be instituted.
4. The same must be said of the water situation.
5. Feeding the native population is still a big item. Most are underfed. Japanese food won't last forever and transportation is now overstrained and inadequate.
6. Such infectious diseases as yaws and Tbc must be segregated and treated promptly.
7. The Mennengon Camp is at present being operated as efficiently as one could expect after four days' supervision, but this will *not* continue to be true unless the above conditions are complied with.

stepped into the water. I swam to a life raft not far away. There were two wounded on the raft and others trying to get on. I ordered all the able-bodied to hang on the side lines and swim with the wounded as fast as possible from the sinking *McKean*. By the light of the burning oil we saw her for a moment, with her bow pointed straight up, before she slid forever into the sea's depths. We all saluted. Seconds later, her armed depth charges went off in the water. It felt like a punch in the stomach.

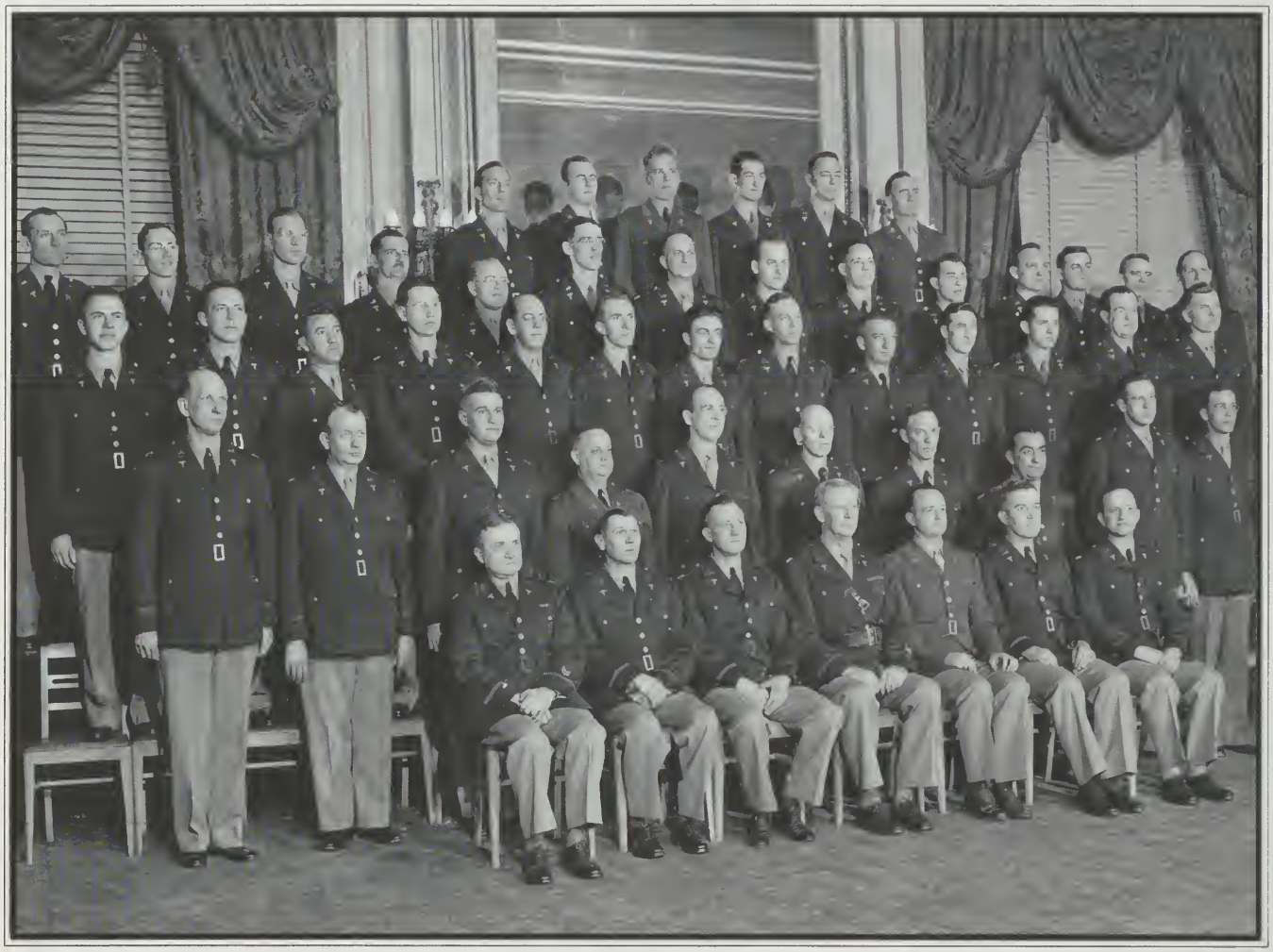
The sea was covered with flotsam to which survivors were clinging. I could dimly see one such man hanging on to an orange crate. After instructing those on the raft to sing "Roll Out the Barrel," I swam to him and dragged him back in the darkness, following the sound of the singing. When dawn came, a lone Japanese plane flew overhead and strafed us in the water. His aim was poor, for the bullets passed harmlessly 20 or 30 feet away. All of us were coughing or spitting up black oil.

That afternoon, we were picked up by one of our destroyers whose captain, when he saw us get hit and burn, had told his crew, "There won't be any survivors." We were lucky. Counting the troops we were carrying, the mortality was 43%—about every other man.

Later, in New Caledonia, I saw our captain. He and the surviving crew were ordered stateside. Me? I was told that there was a shortage of doctors, and, since I had not been seriously burned, I was to stay on and "fight the war."

I finally got home a year and a half later.

Ed. Note: Dr. Williams, a retired neurosurgeon, lives in Bethesda, Maryland. ■



Physicians of the University of Maryland's 42nd and 142nd General Hospitals, Spring 1942

L-R (back row - row #1): Frederick Vollmer, Robert Mearns, William Long, King B.E. Seegar, Henry Rigdon, George Pollock.
2nd Row: Frederick Waknitz, Carl Bailey, Everett Diggs, Frank Dickey, Kennedy Waller, William Helfrich, Walter Karfgin, Robert Crawford, Stuart Coughlin, George Brouillet, Edward Cotter, Edward Streidl, Edwin Muller, Ephraim T. Lisansky.
3rd Row: James Karns, Edwin Dave, Samuel Bryant, Arthur Siwinski, Lauriston Keown, Harry Bowie, Daniel Greiner, Brice Dorsey, Douglas Browning, John Cronin, Byron Inman, Theodore Schwartz, Benjamin Allen
4th Row: Robert Mitchell, Murray Copeland, Henry Ullrich, Samuel Helms, Harry Hull, H. Whitman Newell, Thomas Coonan, Simon Brager, Howard Mays, Cecil Fitzpatrick.
5th Row: Walter Merkel, Vernon Langeluttig, Monte Edwards, Maurice Pincoffs, George Yeager, Lewis Gundry, Walter Kirby.

Photograph courtesy of George Yeager, M.D.

The 42nd General Hospital

Marion Friedman, M.D.

. . . . . .

At the request of the Surgeon General of the Army, the 42nd General Hospital was developed in March 1940, as a reserve unit to be activated in the event of war. Maurice C. Pincoffs, M.D., professor of medicine and chairman of the department, was appointed director of the unit. Chiefs of the various services were selected and assistants considered. Nurses and some paramedical personnel were recruited. A number of its members were ordered to report for training in hospital administration at the Army Medical Center in early 1942, several months before the unit was activated. Two officers attended the tropical medicine course at the Army Medical College.

The Army at first refused to allow Dr. Pincoffs to be activated because he had varicose veins. He was so intent on being part of the effort, however, that he had the veins repaired, even though they were not interfering with his activity or causing any significant symptoms.

On April 15, 1942, the staff of the University of Maryland gave the 42nd and 142nd general hospitals a farewell dinner; Dr. Harry C. Byrd, president of the university, and H. Boyd Wylie, M.D., dean of the medical school, led the well-wishers. Within five days, members of the 42nd unit were en route to their first temporary encampment at Fort Custer, Michigan, where enlisted personnel were added, individual equipment allotted, and immunizations administered. Spending about two weeks there, they learned about Army inspection and terminology, military courtesy and law, chemical warfare, and Army ward routines and drills. Then the unit was again entrained for a two-day, three-night trip to San Francisco.

The train ride to San Francisco was reported to be interesting and scenic, but "a good deal of money changed hands between Fort Custer and San Francisco." While the unit waited to board ship, the officers and enlisted men were quartered at a dog race track in south San Francisco and the nurses were put up at a hotel in the city.

After an unescorted, circuitous, but uneventful trip across the Pacific on the U.S.S. *West Point*, the group arrived at Melbourne, Australia, and was transported by train from the docks to Royal Park, the Zoological Gardens of Melbourne. The camp, which the Yanks renamed Camp Pell, was only a few minutes' ride from the center of the city, so most spent every evening they could in town. The Aussies received them with much warmth.

A most unfortunate incident occurred in Melbourne. Maj. Thomas J. Coonan, a Baltimore pediatrician in civilian life and one of the unit's most popular physicians, fell from a trolley car, struck his head, and ultimately died from the injury.

In early July, the unit moved by train to Queensland, a more northern and more tropical state. The trip involved two nights without sleeping accommodations and a change of trains at the border of New South Wales (each state had independently determined its own rail gauge). The destination was Camp Redbank, located about 20 miles from Brisbane; after about two weeks, the personnel nicknamed it Camp Mud-

bank. The 42nd "Cosmetic Squad" (including the physicians) quickly began working to drain the area and build roads. The quarters were "streamlined lean-tos" that allowed air to circulate freely, an asset in the tropical climate. Within two weeks, however, they were moved a relatively short distance to Stuartholme, which overlooked Brisbane and the river. The three-month-old, nomadic unit would finally be located at a more permanent site, which they would occupy for 16 months, tending to battle casualties and learning first-hand the ravages of war. They would also be developing an organization the reputation of which would be unexceeded in the entire area.

The property the unit acquired had been a convent school at the top of wooded hills. It totaled approximately 80 acres, much of which could not be used. It was picturesque, presenting a beautiful view of Brisbane and the river, but required extensive building and remodeling to convert it to its intended use. Although water came from the city as well as a large cistern that collected rain water, it had to be pumped up the hill into two large tanks under the roof of the main building because there was not enough pressure. An almost entirely new water system and sewage system ultimately had to be installed. Extensive wiring and plumbing were needed for radiographic and other facilities, including patient wards, a dental clinic, EENT clinic, cystoscopy room, clinical laboratory, morgue, diet kitchen, and dishwashing room. Detachment areas were constantly being constructed for every imaginable purpose, and space that initially had been assigned one function was used for another.

Despite all the concurrent activity, the hospital officially opened July 20, 1942, with the transfer of 60 patients from a station hospital. Before the hospital closed on December 24, 1943, it had admitted 7,920 patients.

Because construction space was so limited, a second site 12 miles away that had been occupied as a station hospital was acquired as a convalescent section. Known as Camp Columbia, it too had to be converted from a few wooden barracks and ward tents amidst heavy underbrush to an orderly hospital equipped with electricity, plumbing, and all the other necessities. At one period, the convalescent section housed 800 patients.



Disinfecting clothing of recovered Allied prisoners of war at 42nd General Hospital, Tokyo, Japan.

Reprinted from Coates JB Jr, Havens WP Jr, eds. *Medical Department, United States Army. Activities of Medical Consultants.* Vol. I. Washington, DC: Office of the Surgeon General, Department of the Army; 1962:57.

When it became clear that adequate facilities could not be made available at the main hospital site for the mentally ill, a third site was established at Goodna, which was about one and a half miles beyond Camp Columbia and about ten miles from the primary hospital at Stuartholme. Section III opened September 1, 1942, and remained in operation until October 29, 1943.

From its activation until February 1943, the 42nd was under the command of Col. Pincoffs. When he was detached to serve as chief consultant in medicine for the U.S. Army Forces Far East, Lt. Col. Clyde S. Tartar of Michigan was placed in command for about three months. Col. George H. Yeager of Baltimore, who had been chief of surgery since the unit's activation, was then placed in command. He remained in command until the 42nd was deactivated.

During the last months of 1943, because additional bed space was needed, the unit moved to a new site at Holland Park in Brisbane. The move consolidated its three sections and allowed it to be considered a 1,000-bed facility. It also allowed the acquisition of specialist physicians that previously had been lacking. Those who had been at the compact, main section at Stuartholme had to adjust to a more temporary type of construction spread over a wide area, with buildings often connected by elevated ramps protected from the elements by a roof and one side.

In May 1945, the unit moved to Manila, the Philippines, where it camped in a mud field, functioned out of tents, and tended to a few casualties until more permanent facilities could be built on the site. In August, however, the atomic bombs were dropped and the unit was ordered to Yokohama (the water route to Tokyo) to process prisoners who were being released.

In February 1943, Col. Maurice C. Pincoffs was moved to the Office of the Chief Surgeon, Headquarters, U.S. Army Forces in the Far East (USAFFE), to serve as Chief of Professional Services.

Col. Pincoffs, by both background and experience, was admirably suited for his new position In World War I, he had served with troops in an aid station and had been awarded the Distinguished Service Cross for bravery. Between the World Wars, his position as professor of medicine at the University of Maryland School of Medicine had given him heavy teaching and administrative responsibilities. When World War II began, he organized a 1,000-bed general hospital recruited from the staff of the University of Maryland. When it became apparent that a unit of such size would have a long wait for overseas duty, he persuaded the Surgeon General to divide it into two 500-bed hospitals and to send them overseas promptly. His training was rounded off by firsthand experience with the problems of his own hospital after it arrived in Australia, where he had some contact with casualties returning from New Guinea.

Almost overnight, Col. Pincoffs became director of all phases of professional medical operations in the Office of the Chief Surgeon, Headquarters, USAFFE. He performed many of the duties of consultant in medicine until the arrival of Col. Henry M. Thomas, Jr., M.C., in October 1943. Col. Pincoffs represented the Chief Surgeon on all professional matters, particularly those that required cooperation with other headquarters or other branches of U.S. Army, Services of Supply (USASOS). With Capt. Howard F. Smith, U.S. Public Health Service, he also represented the Chief Surgeon on the Combined Advisory Committee on Tropical Medicine, Hygiene, and Sanitation. This committee, composed of representatives of the armies, navies, and air forces of the United States and Australian commands, reported directly to General MacArthur.

Col. Pincoffs edited technical bulletins and reviewed all reports, including those from various research projects. He handled arrangements for the United States of America Typhus Commission. He directed the policies and activities of the Preventive Medicine section, which consisted of a single health officer with almost no army experience, a situation which could not be corrected because of lack of contact with the Office of the Surgeon General. Col. Pincoffs also advised with the surgical and neuropsychiatric consultants, and reports from the Dental, Veterinary, and Nursing Sections passed over his desk.

Col. Pincoffs continued to perform these duties in Headquarters, USAFFE, until June 1945, except for the period between October 1, 1943 and January 21, 1944, when he served in the same capacity in Headquarters, USASOS.

When the Chief Surgeon's Office moved to Luzon, on April 12, 1945, the consultants followed. Manila was a pile of dust and debris. The destruction of large parts of the city, the U.S. bombardment, and Japanese demolition in their retreat completely wiped out the distribution of water and electricity and destroyed all sanitation. The danger of ravaging outbreaks of cholera and all manner of dysenteric diseases was enormous, and local public health agencies had been either destroyed or demoralized. This problem was the responsibility of Col. Pincoffs, who had been assigned as director of public health in Luzon and who successfully managed this unplanned-for emergency.

From: Thomas HM Jr. Southwest Pacific Area. In: Coates JB Jr, Havens WP Jr, eds. *Medical Department, United States Army. Internal Medicine in World War II. Activities of Medical Consultants.* Vol. 1. Washington, DC: Office of the Surgeon General, Department of the Army; 1961:476-478,490.

Their first site was a temporary quarter set up in a dockside warehouse of Yokohama Bay to process the prisoners who were being released from all over the area. The procedure included a quick evaluation of their conditions, delousing by dusting with DDT, showering, and providing food and clothing. Those who required additional medical attention were transferred to one of the ships docked at the port or flown to more appropriate medical facilities as the situation required. Prisoners who had been detained closest to Tokyo showed the most evidence of malnutrition and poor care, while those who had been detained in more rural areas had fared better. During the month or so that the unit worked from the dock, they processed more than 20,000 people. The unit was then transferred to the St. Luke's Episcopal Hospital, which had been built before the war, largely with American funds donated by the church. The hospital was a modern medical facility that would have been much more useful during the war.

The original members of the 42nd General Hospital had long been eligible for rotation home, and by December 1945, all had returned to the United States, having been replaced by non-Marylanders. The unit received a commendation from General MacArthur for its service.

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Physicians of U.S. Army General Hospital 42

Commanding Officers
- Col. Maurice C Pincoffs*
- Col. Clyde S. Tarter
- Col. George H. Yeager**

Chiefs of Surgery
- Brig. Gen. George H. Yeager
- Col. Henry F. Ullrich
- Lt. Col. Harry C. Bowie

Chiefs of Medicine
- Lt. Col. Lewis P. Gundry
- Lt. Col. Walter E. Karfgin
- Maj. Edward F. Cotter

Chief of Laboratory
- Lt. Col. Walter C. Merkel

Chief of Radiology
- Walter Kilby

Chief of EENT
- Maj. Theodore A. Schwartz

Other personnel
- Lt. Col. Brice M. Dorsey
- Lt. Col. Robert B. Mitchell, Jr.
- Maj. Ernest B. Brooks
- Maj. Thomas J. Coonan
- Maj. Robert C. Crawford
- Maj. Thomas F.B. Darnell
- Maj. Charles W. Grady
- Maj. Herbert D. Hebel
- Maj. Ceirianog H. Jones
- Maj. James H. Mackin
- Maj. Vern W. Miller
- Maj. Sidney Rubenfeld
- Maj. Edward G. Streidl
- Maj. John E. Taylor
- Maj. Hugh H. Trout, Jr.
- Maj. Charles W. Reavis
- Maj. Gilbert E. Rudman
- Capt. Carl E. Bailey
- Capt. George D. Canatsey
- Capt. Everett S. Diggs
- Capt. Robert W. Fick
- Capt. Richard D. Garrett
- Capt. Byron W. Inman
- Capt. William B. Long
- Capt. Ernest W. Mack
- Capt. William G. Mason
- Capt. John O.D. McCabe
- Capt. Charles E. McCracken
- Capt. Anthony W. Miles
- Capt. Anthony A. Mira
- Capt. Irving L. Moskowitz
- Capt. Arthur A. North
- Capt. Israel Orris
- Capt. James N. Palmer
- Capt. George F. Pollock
- Capt. Thomas K. Prindable
- Capt. Maurice A. Rickelman
- Capt. Ernest P. Runnells
- Capt. Sidney H. Shapiro
- Capt. John L. Shea
- Capt. Daniel J. Shempa
- Capt. Sam Silver
- Capt. Arthur G. Siwinski*** (later colonel)
- Capt. Leonard K. Stalker
- Capt. Richard L. Sutherland
- Capt. Frederick J. Vollmer
- Lt. James D. Boole
- Lt. Cecil C. Fitzpatrick
- Lt. Norman F. Jacobs
- Lt. Thomas Knight
- Lt. Edward C. Leaphart
- Lt. Earl B. Mitchell
- Lt. Nils Falk
- Lt. Ernest J. Schneider, Jr.

* *Dr. Pincoffs was the 1953 president of Med Chi.*

** *Dr. Yeager was awarded the Legion of Merit. He was the 1955 president of Med Chi. In 1952, he founded the* Maryland State Medical Journal *and served as its editor until his retirent from that post October 1, 1966.*

*** *Dr. Siwinski was the 1968 president of Med Chi.*

Reminiscences of the 42nd General Hospital During World War II

Col. Arthur G. Siwinski, M.C.

In 1940, when medical training centers began to organize general hospitals for deployment when the United States entered World War II, the military was very stingy in bestowing grades on doctors. Most of us were in the company grade (i.e., captains and lieutenants). Majors were required to be chiefs of major services; even the commander of the 42nd General Hospital was only a lieutenant colonel. How different from the present!

While being transported from San Francisco to the Southwest Pacific, we soon learned how quickly situations change during periods of armed conflict. Six of us were assigned a stateroom on the top deck with three double-deck bunks and two large windows, one on the starboard and the other at the stern. We felt rather privileged having such an airy room. Shortly after we crossed the equator, however, the Navy gunners decided to test their guns and we quickly learned that one battery was directly over the roof of our cabin. With the first salvos, every window in our stateroom was shattered. From then on, we had no fresh air because our windows had to be tightly boarded up. We also had to pick glass out of our blankets for the rest of the trip. The second lesson occurred a day or so later when it was reported that two-man Japanese submarines were shelling Sydney Harbor, which resulted in our destination being changed to New Zealand. After a day and a half without leaving the ship, we sailed for Melbourne, Australia, where we were bivouacked in the park area of the Royal Melbourne Zoo. We remained there until intelligence definitely established that there were no Japanese naval elements anywhere south of New Guinea.

We were very well received at Melbourne, a city very similar to London, including left-handed traffic, which caused the first tragedy of our unit. Coming home one evening, one of the senior officers stepped off the rear platform from the right-hand side of the trolley car, instead of the left. In doing so, he stepped into the path of oncoming traffic. He was severely injured and died after a few days.

In due time, we were transported by rail to the north. At the border of Victoria and New South Wales, we had to change trains because the rail system in Victoria was of the old-fashioned wide rail that was prevalent in England and Europe. In New South Wales and Queensland, the rail beds were the same as those in the United States. Our destination, Brisbane, was at the hub of military activity for the region, including Gen. MacArthur's headquarters, representatives of the royal Dutch military, representatives from the nationalist Chinese government, and a Navy base from which submarines went out to the Pacific to gather information. In the area were a number of hospitals, several general hospitals, and station hospitals waiting for construction of hospital space to be completed. On the fringes of Brisbane was a large brick boarding school run by Catholic nuns for young ladies. They had offered the school to the U.S. government and it was under reconstruction to accommodate a hospital. When the work was completed, the 42nd General Hospital was chosen to use it as a base.

The 42nd conducted a convalescent camp for soldiers who were being returned after recovery to limited or full duty. During a rotation through the camp, I had a rather deflating experience. I had been a second lieutenant in the infantry, having received a commission when I graduated from the Reserve Officer Training Corps at Hopkins in 1927, and I was noted for being able to bark out commands. On one occasion when a unit was scheduled for close order drill, the administrative officers were busy working on rosters and asked if I would lead the drill. I consented, but when I gave orders to the men, I got responses I had not expected. Sometimes nothing happened at all. It was soon evident that I was not on the same wavelength with the men and I realized that the Manual of Arms I had learned in 1927 was no longer valid: the same commands produced a different response. Fortunately, one of the administrative officers finished early and rescued me.

On another occasion when I was a receiving and disposition officer, base informed us that we were to evacuate 1,500 patients within 48 hours. There was a great deal of scurrying to get our patients ready with all the paperwork. Capt. Fred Vollmer, M.C., accompanied me as we took the patients out to the ship. When we got there, we had to account for every individual, be sure he had his paperwork, and be sure it corresponded with the base copies. We finished fairly late in the afternoon, only to find that while we were working a general had commandeered our yacht, leaving us stranded for the night. There were so many troops aboard the transport, the only place Fred and I could stay was in the locked section of the ship with the psychiatric patients. We found a comfortable place on the floor and, with our blankets, settled in for the night. We were fortunate the next morning: we did not have too much trouble convincing those in charge that we were not psychiatric patients, and we were able to get out and back to our unit.

In December 1944, we were alerted that our unit might be sent to the Philippines. Just before the end of the month, word came from the base that there were several spaces available for anyone who would like to be rotated back to the States. I was one of those chosen. When I returned, my first assignment was at Camp Pickett, Virginia, to a general rehabilitative hospital. When I arrived there, the chief of surgery was Paul Kunkel, a graduate surgical resident from Hopkins.

Ed. Note: President of Med Chi in 1968, Dr. Siwinski retired from the practice of head and neck surgery in 1971. He lives in Largo, Florida. ■

AMONG thirty-five distinguished scientific leaders representing twelve general fields of science who were elected to the National Academy of Sciences at the annual meeting were seven men in the field of medical science. They include . . . Dr. Alfred Blalock, professor of surgery at Johns Hopkins University, who is noted for his studies of shock and, more recently, for finding that myasthenia gravis can be successfully treated in some cases by removal of the thymus gland in the chest.

JAMA 1945;128:38.

NURSES OF THE 42ND

Col. Ida M. DeVese, A.N.C.

Unbeknown to most of its future members, the seeds of the 42nd General Hospital were planted in May 1940. Although considerable thought was given to staffing before war started, immediate acceleration of activities occurred after the declaration of war on December 7, 1941. Grace E. Dick was appointed Chief Nurse; Ruth C. Frothingham, her assistant. Nursing recruitment began in earnest. Nurses from many hospitals in Baltimore and surrounding areas applied and ninety were accepted as members of the 42nd. The majority of nurses were from University Hospital; the rest came from remaining area hospitals and institutions.

On April 24, 1942, the nurses boarded a train at Pennsylvania Station. Suitcases, footlockers, families, and friends filled the station. Many tears were shed but the nurses were eager to get started on their first taste of Army life.

The train arrived at Fort Custer, Michigan, April 25th. A small Army hospital on the base gave most of us our first contact with Army life. The nurses rotated working at the hospital, but most of our time was spent learning about the more military subjects like drilling and gas mask use. Standard issue for nurses was gas mask, musette bag, canteen and mess kit; uniforms at this point were still missing. Ten days after our arrival, we were told to pack our bags and get ready to move. What a motley crew! We wore civilian clothes with gas masks, canteens, and mess kits hanging from our pistol belts.

We boarded the troop train with enthusiasm and expectation. We were really in the Army now!

We arrived in San Francisco on May 9 after a tiring and hot train ride, eager to see what awaited us. The nurses quartered in one of the downtown hotels. We finally received our uniforms after a 10:00 p.m. march to a city warehouse. We had been told the Army had two sizes—too large and too small on the list.

The uniforms were on a table in this huge structure; we were given a list with the number and type of each item we were to have. Trying to get the proper size proved frightful. Selection was extremely limited, but fit or no fit, we had to have everything. We made selections as best we could and spent the next day trying to get our uniforms altered. Sewing machines supplied by the Red Cross had us looking presentable and ready for overseas duty.

May 18, we boarded the *West Point* and sailed under the Golden Gate headed out to the Pacific. About 8,000 personnel were aboard ship. (The *West Point* had been the *America*, the largest cruise ship in the United States at the time.) While on board, we practiced boat drills and played cards. Our "Mae Wests" (life jackets) went with us everywhere.

After fifteen days at sea without sighting land, we arrived at Wellington, New Zealand. We were not allowed to disembark. We did manage to provide eight nurses with a graduation celebration of sorts. (They had finished training in February, but left Baltimore before graduation ceremonies). I was one of the eight, and we were treated royally for a day. We wore homemade cardboard graduation caps, received diplomas and had a special dinner in the mess hall. The unit baker made a cake decorated with the Maryland flag.

The next day, it was on to Melbourne, Australia, where we boarded the train for Canberra, the capital city. Thinking it would be a fair-sized city, imagine our surprise when the train pulled up alongside a wooden building surrounding by fields of grazing sheep. There was a station master and no one else. No one had been expecting us. After a long wait and many telephone calls, buses took us into the main city and deposited us at the Canberra Hotel. Our luggage, however, decided to stay in Melbourne. We had only what we had packed in our musette bags to hold us until our luggage arrived. It was a week of nightly washing and improvisation.

Canberra was a beautiful country town and the Australian people were hospitable and kind. They invited us into their homes for tea, which we found out was dinner. They did everything possible to make us comfortable for the six weeks we were there. The plans were that the Americans would take over a civilian hospital which was under construction; but like many Army plans, it was changed. We hated to leave, but boarded a train again, this time bound for Brisbane.

The hospital was established in a Catholic girls' school called Stuartholme. Here, after much hard work and many renovations, the 42nd General Hospital was set up and ready to receive patients. We treated patients from all services—Army, Navy, Air Force, and Marines—serving in New Guinea and the South Pacific. Many were battlefield casualties, but many were also victims of malaria and dengue fever. There were cases of tuberculosis, pneumonia, intestinal disorders, common colds, and sore throats. Skin diseases from living in jungles and heat were also very prevalent. Mental disorders were also treated. Patients who could be cared for and cured within 90 days were returned to their units. Those requiring treatment beyond this time were returned to the Zone of Interior for further disposition.

In addition to working hard, we did have lighter moments. The nurses never had problems finding a date. Almost every night the telephone would ring and an officer (it was against regulations for a nurse to go out with an enlisted man) would ask if any of the nurses wanted to go out tonight. We also had visits from many celebrities. Mrs. Eleanor Roosevelt and Joe E. Brown, the comedian, were the two most notable ones who visited the hospital and talked with the men. The 32nd Division Army Band came frequently and regaled us with popular tunes.

The hospital stayed at Stuartholme for 16 months and then moved to a location called Holland Park, where Army Engineers had constructed a more conventional Army hospital. It consisted of one-story wooden buildings all connected by ramps. It offered more space and facilities to care for patients than Stuartholme, but certainly not the view. I returned stateside in June 1945.

Ed. note: Ida M. DeVese entered the Army Nurse Corps as a second lieutenant in 1942. After her discharge as a first lieutenant in 1945, she remained in the Organized Reserve Corps until 1980, when she retired as a colonel. She lives in Baltimore. ■

THE WAR Department reveals that war casualties for the week ended July 29 were 2,806, making a total of 1,061,648 since December 1941. Army losses are 197,676 killed, 570,766 wounded with 351,317 returned to duty, 34,734 missing and 117,741 prisoners of war, with 95,709 exchanged or returned to military control, making a total of 920,917. Navy losses are: Navy, 31,498 killed, 23,054 wounded, 10,547 missing, 2,038 prisoners, total 67,137; Marines, 19,385 killed, 50,465 wounded, 909 missing, 1,719 prisoners, total 72,478; Coast Guard, 808 killed, 213 wounded and 95 missing, total 1,116.

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Observations of a Medical Consultant

Col. Henry M. Thomas Jr., M.C.

Consultant in Medicine, Fourth Service Command (Southwest Pacific Area), August 1942 to August 1943

Dermatology. Dermatology should be a separate service; separate, that is from venereal diseases, with which it was so often combined. There was a surprising dearth of well-trained dermatologists. In retrospect, it seems it would have been worthwhile to collect a few superior dermatologists and send them around to the various hospitals as instructors. Perhaps, schools of dermatology could have been established, but Army dermatology is rather stereotyped and does not cover a very wide field. A basic dermatologic training given to all officers on medical services would be valuable, particularly in tropical areas. The medical consultant always visited the dermatologic cases; however, he contributed nothing but encouragement and interest.

Venereal diseases. In some hospitals, syphilis and dermatology were treated on the medical service and gonorrhea on the surgical service; in others, syphilis and gonorrhea were both treated on the surgical service; and, in still other hospitals, syphilis and gonorrhea were both treated on the medical service. It is a matter of some importance that the responsibility for therapy should be uniform. In this consultant's opinion, syphilis is entirely a medical disease, and gonorrhea is a medical disease with a very rare surgical complication. It is true that a certain number of genitourinary surgeons specialize in the treatment of gonorrhea, while it is difficult to find any officers on the medical services who have had experience with treatment of gonorrhea. Furthermore, chiefs of medical services take very little interest in gonorrhea cases. These officers have learned about the disease in this war, and, from now on, gonorrhea will become a medical disease.

Neuropsychiatry. One of the most generally neglected phases of therapeutics in the leading medical schools of the country is so-called psychosomatic medicine. The Oslerian school treated these cases with a characteristic wave of the hand and pat on the back, went to the next patient with a heart murmur, and from there went to the pathology laboratory. The usual teacher of clinical medicine finds it difficult to crowd into the small number of hours the amount of learning essential to the fundamentals of diagnosis. When it comes to the

time-consuming and somewhat subtle expositions of the patient as a whole and the part the psyche plays in symptomatology, the clinical teacher often feels himself at a disadvantage and avoids undertaking a complicated role. It was the medical consultant's experience that, by and large, the ward officers in the station hospitals in the Fourth Service Command had very little conception of the patients' worries and the psychologic aspects of the patients' treatment. This consultant, early in his Army experience, became interested in the functional aspects of duodenal ulcer cases and referred to this subject in discussions of the wider field of psychosomatic symptomatology. This, however, cannot be taught by Army consultants alone and actually is the responsibility of the medical school curriculum. In the Army, the consideration of the patient as a whole involves the morale of the patient as a soldier.

It was discovered early in visits to hospitals that a great deal of useless routine laboratory work was being ordered for and performed by laboratories that were often already overloaded. . . . When this was brought to the attention of the surgeon of the service command, an order was immediately circulated forbidding routine laboratory work and directing that each test would be ordered according to its own merit. Surprisingly enough, this seemingly simple directive caused confusion and was interpreted by some medical officers to mean that no case should be thoroughly studied. . . . The need for a laboratory consultant was clearly evident.

Laboratory activities. There should be a laboratory consultant in each service command, and theater. He would be one of those rarest of all medical officers, an excellent clinical laboratory man. By and large, the laboratory service was the worst in the hospital. There were not enough good, general, clinical laboratory men to go around nor nearly enough technicians. Later, this shortage was partially filled by Army schools for technicians, but this deficiency still reached into the theaters of operations, where it was even more noticeable.

When the medical consultant to the Fourth Service Command found a laboratory problem, he, with the chief of the medical service, and the ward officer involved, would go directly to the laboratory service. There a discussion would be undertaken on the indications for laboratory examinations, the results, the techniques, and other pertinent information. It was a very rare thing to find a medical ward officer who went directly to the laboratory with his problems. On the other hand, the laboratory almost always sent a rather poorly trained technician to the ward to handle specimens. The result was that many tests were unreliable, specimens were mishandled, and there was no close cooperation between the clinical laboratory and the ward. This problem was taken up regularly in each of the hospitals with the chief of the medical service, the chief of the laboratory service and with the two of them together. . . . An assistant medical consultant should be appointed with duties confined to clinical laboratory work. This laboratory consultant should function in the professional consultants' section in the office of the service command surgeon.

Clinical Research. There were several clinical research projects in some of the hospitals. Some officers turned out a great many papers; a few of them were quite good. Whenever the medical consultant saw an interesting and unusual case or a well-studied group of cases, he encouraged the chief of medical service and ward officer to prepare a report for publication. The Fourth Service Command Laboratory was interested in various studies including dysentery and meningococci infection.

The influenza commission was established at Fort Bragg, NC, where primary atypical pneumonia was studied. Members of the staff of that commission contributed to the program of a conference held in the service command and distributed information concerning their work. The large epidemic of meningococcic infections presented an opportunity for careful clinical and therapy studies. At Fort Bragg, Lt Col (later Col) Worth B. Daniels, MC, studied an outbreak of a rare disease, which he called pretibial fever. On the whole, the medical personnel in the hospitals of the Fourth Service Command were not trained for clinical research. There were a number of cardiologists who collected rare forms of cardiac arrhythmia, and the gastroenterologists made valuable contributions to the study of peptic ulcers. The work on the use of prophylactic sulfonamides in aborting a meningococcic epidemic was of great value, and the studies along this line performed by the Fourth Service Command Laboratory personnel were outstanding.

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Ed. Note: Dr. Thomas died in 1966. ■

THE 142ND GENERAL HOSPITAL

Marion Friedman, M.D.

. . . . . .

THE 142ND GENERAL HOSPITAL was one of the two units formed at the University of Maryland. Created on Easter Sunday, 1942, the 142nd was activated April 20 and ordered to report to Fort Riley, Kansas. There it spent about two weeks receiving its equipment and inoculations, being indoctrinated, and adding its support personnel. It then left for San Francisco for embarkation to a destination unknown (for security reasons).

Leaving San Francisco May 26 aboard the U.S.S. *Uruguay,* which had not yet been fully converted to a troop ship, members of the 142nd zigzagged across the Pacific, escorted by a cruiser and four other ships. They arrived without incident in Auckland, New Zealand. When they reached port, the New Zealand Army Band was waiting to greet them and played "Stars and Stripes Forever" for a full 45 minutes, after which it performed the "Star-Spangled Banner." When the New Zealanders had completed their welcoming music, the ship's band returned with "Roll Out the Barrel" and "God Save the King." The soldiers then marched with full packs to a nearby entrainment area to be taken to Camp Papakura, which was outside Auckland.

Built on swampy ground, the camp was damp and poorly heated (June is a winter month in the southern hemisphere) and, due to short rations, they had to go on a light diet. As a result, many developed colds, grippe, and sinus conditions. Nevertheless, the New Zealanders went all out to welcome and entertain them.

On June 23, they left New Zealand on the USS

The unit at Tamavua tried to create a home-like atmosphere at its island site. They gave home names to their streets and they dubbed their two military telephone circuit exchanges "Baltimore" and "Maryland." At the post exchange they could purchase a number of nonissue items and simple luxuries, such as a cold Coca-Cola. They spent occasional weekends sightseeing, swimming, deep-sea fishing, and observing moving pictures or performances by native amateur talent. One not-so-homey experience was the evening spent combating hoards of tiny mice. At other times, thousands of frogs would periodically descend from nowhere; they were particularly fond of the nurses' shower. One evening, a nurse awoke to find a live cow in her room.

On April 23, 1942, Marion H. Gillis, M.D., a 1936 graduate of the University of Maryland School of Medicine, was busy seeing patients in Salisbury. About 8:00 p.m., he received a telephone call informing him that he had orders to report for active duty with the 142nd General Hospital that same day. Stopping long enough to pick up his uniform, remove the sutures from a patient's eye, and have dinner at the home of his brother-in-law, he left for Baltimore, where he caught the train for Fort Riley, Kansas.

Like others who served with the 142nd, he would eventually go around the world: from Baltimore to Fort Riley to San Francisco to Auckland to Fiji to Calcutta to Casablanca to Bermuda to Miami to Baltimore. The trip, however, lasted about three years longer than 80 days.

Retired from the practice of ophthalmolgy, Dr. Gillis lives in Salisbury.

Mary Ann Ayd

Source: Gillis MH. Telephone interview, September 12, 1995.

President Coolidge for the Fiji Islands, where they went ashore five days later. They were then taken by army trucks 150 miles across the island via King's Highway through exotic jungle. When they finally arrived at their journey's end, Lautoka, they found that they had not been expected and neither food nor lodging was available. They had to survive on C rations and fresh pineapples. From a local Chinese baker they were able to obtain bread, which they ate with jam.

Lautoka, however, was to be only a temporary stop. By the end of the first week of July, they moved to a barren stretch of mountain nearby in the Saheta Valley, where temperatures by day could reach 130 degrees and averaged about 70 degrees at night. When they arrived, their site was nothing but two ramshackle warehouses surrounded by acres of head-high grass. They constructed a tent-type hospital that opened July 12, but before they were even ready to accept patients, Maj. William W. McKinney, a University of Maryland graduate from Houston, Texas, performed the first operation, an extradural abscess. The dental section set up two rickety chairs between the two old buildings and Maj. Douglas A. Browning extracted a tooth. After providing the tent-like hospital, they proceeded to erect more substantial buildings.

It was not until November, however, that the unit began receiving significant casualties, the first being a group of 600 Army, Navy, and Marine personnel coming by ship from Guadalcanal. They had sustained not only fractures and other wounds produced on the battlefield, but burns and multiple traumas, the result of shipboard injuries inflicted by the enemy from the air. Later, these types of casualties were transported more efficiently by air. The hospital also treated malaria (particularly a strain from the Solomon Islands

Thursday, September 30, 1943

"Back at the 142d General Hospital. An excellent orthopedist here [Fiji]. They are about to lose two men from their surgical staff of nine. The mess is excellent. As at the 18th General, all of these men are anxious to go to the front with a surgical team. Colonel Dovell thinks that is a great mistake to send good men to the front where they might be lost. However, he can be convinced."

From the diary of Col. Ashley W. Oughterson, M.C., surgical consultant in every major command in the Pacific theater.

Source: Coates JB Jr, Carter BN, McFetridge EM, eds. *Medical Department, United States Army. Internal Medicine in World War II. Activities of Surgical Consultants.* Vol. II. Washington, DC: Office of the Surgeon General, Department of the Army; 1964:799.



Staff of the 142nd General Hospital at New Caledonia, before going to Fiji, 1943.

L-R, 1st row kneeling: Edmund V. McKinley; Edwin O. Daue, Jr.; Douglas A. Browing; William C. Humphries; John L. Atkins; John K.B.E. Seeger; Russel P. Brunkhorst; William G. Hoppe; John W. Cronin; Robert L. Gibbs; Porter

2nd row kneeling: Peters; Harry M. Robinson; Ephraim T. Lisansky; Henry L. Rigdon; William G. Helfrich; James R. Francis; Daniel J. Greiner; Oliver James

3rd row standing: Chaplain Andy Farriker; Graves; Frederick W. Waknitz; Marion H. Gillis; Walter L. Kilby; Francis G. Dickey; Joseph Hellewell; Harry V. Langeluttig; Murray M. Copeland; Harry C. Hull; Howard B. Mays; Horatio W. Newell; Samuel H. Bryant; William W. McKinney; George H. Brouillet; Stuart G. Coughlan

Reprinted from: Coates JB Jr, Carter BN, McFetridge EM, eds. *Medical Department, United States Army. Internal Medicine in World War II. Activities of Surgical Consultants.* Vol. II. Washington, DC: Office of the Surgeon General, Department of the Army; 1964:800.

that was more resistant to therapy), dengue fever, dysentery, and skin disease. At one time about one half the hospital corps was incapacitated with dysentery.

As frequently happened all over the war area, when all were finally living under wooden roofs, in January 1943, they received orders to move. This time, however, the journey was only across the island, by air, to an almost new wooden structure at Tamavua. By April, they were caring for 740 patients in a facility built to care for 300. Again an extensive building program was

> *"**Dengue.**—This protean disease is characterized by 5 to 7 days of fever, either so-called saddleback or continuous; headache; retro-orbital pain; conjunctival suffusion; backache and periarticular muscular pains; and a rash, which usually appears on the fourth to the sixth day. While there is considerable variation in the severity of symptoms and duration of fever, the diagnosis of dengue when the temperature elevation lasts less than 4 days should be viewed with suspicion. Very mild, afebrile cases of dengue probably do occur, but the differentiation of them from other short fevers is not reliable."*
>
> From: Thomas HJ Jr. Southwest Pacific Areas. In: Coates JB Jr, Havens WP Jr, eds. *Medical Department, United States Army. Internal Medicine in World War II. Activities of Medical Consultants.* Vol. I. Washington, DC: Office of the Surgeon General, Department of the Army; 1961:534-535.

undertaken. While they were there, the first lady, Eleanor Roosevelt, and the comedian Joe E. Brown paid them a visit.

Many of the physicians became actively engaged in research and wrote many scientific papers that later were published. It is of interest that despite the advances of civilization, many of the dental officers carried portable equipment which included old-fashioned, foot-driven engines to supply power for their burrs and drills.

During its 18 months at Tamavua, the unit had three commanders, two of whom were Marylanders. One was Col. Chauncey E. Dovell, a 1912 graduate of the University of Maryland who had made military medicine his career. The other was Col. Murray M. Copeland of Baltimore, who retained that position until all the original medical personnel had left the unit.

During that period, on August 31, staff nurse 2nd Lt. Louise Margaret Hollister of Denton, Maryland, died of dengue fever. She was buried with full military honors in a nearby cemetery.

In late 1943, the table of organization was increased to a 1,000 bed hospital. This was always important because it not only reflected actual or anticipated increased need to accommodate casualties, it allowed many of the officers to be promoted in rank.

As the fighting shifted north, the base became unnecessary. On September 14, 1944, the unit boarded the USS *George M Randall* and after two days, set sail for India (as did the Hopkins 18th unit). En route, the ship stopped at Melbourne, Australia, and the men were given a two-day shore leave, the first time in 29 months they had seen a big city. The leave provided them the opportunity to go sightseeing, shop, and sample foods other than army issue.

When the vessel reached Bombay, India, they received another two-day



142nd General Hospital, Fiji Islands.
Reprinted from: Coates JB Jr, Havens WP Jr, eds. *Medical Department, United States Army. Internal Medicine in World War II. Activities of Medical Consultants.* Vol. I. Washington, DC: Office of the Surgeon General, Department of the Army; 1961:575.

Physicians of U.S. Army General Hospital 142

Commanding Officers
- Col. Chauncey E. Dovell
- Col. A.J. Bayley
- Col. Murray M. Copeland

Chiefs of Surgery
- Lt. Col. Monte Edwards
- Col. Henry C. Hull

Chief of Medicine
- Lt. Col. H. Vernon Langeluttig

Chief of Neuropsychiatry
- Lt. Col. Whitman H. Newell

Chief of EENT
- Lt. Col. Marion H. Gillis

Chief of Radiology
- Maj. Walter L. Kilby

Other Personnel
- Lt. Col. Samuel T. Helms
- Lt. Col. William R.L. Reinhardt
- Maj. Samuel H. Bryant
- Maj. Stuart G.. Coughlan
- Maj. Oliver A. James
- Maj. Ephraim T. Lisansky
- Maj. Howard B. Mays
- Maj. William W. McKinney
- Maj. Harry M. Robinson, Jr.
- Maj. Frederick W. Waknitz
- Capt. John L. Atkins
- Cpat. Louis Battista
- Capt. Allen Beale
- Capt. Howard Billman
- Capt. George H. Brouillet
- Capt. Douglas A. Browning
- Capt. Francis G. Dickey
- Capt. Fred Dye
- Capt. Daniel J. Griener
- Capt. William G. Helfrich
- Capt. Joseph Hellewell
- Capt. Lauriston L. Keown
- Capt. Edmund F. McKinley
- Capt. Robert B. Mearns
- Capt. Claude Peters, Jr.
- Capt. Henry L. Rigdon
- Lt. Benajmin F. Allen
- Lt. Russel P. Brunkhorst
- Lt. John W. Cronin
- Lt. Edwin O. Daue, Jr.
- Lt. James R. Francis
- Lt. Robert L. Gibbs
- Lt. William G. Hoppe
- Lt. Oliver James
- Lt. Joseph Murray
- Lt. Lohn K.B.E. Seegar, Jr.

shore leave that gave them the chance to view conditions in that area of the world. They next were subjected to a very uncomfortable five-and-a-half day trip by rail across India to Calcutta. There was little food and scarce water: the only hot water available for shaving and bathing came from the train engine at its many stops.

When they finally arrived, they were treated to a pleasant sight—spacious, well-built, well-equipped hospital buildings in an outlying residential area of Calcutta. In fact, they were to take over an established installation from the 263rd General Hospital, which was inactivated in November 1944. The daily census was soon running between 1,600 and 2,300. They treated much malaria, amoebic dysentery, smallpox, dengue fever, venereal disease, skin diseases, and psychiatric cases. Their table of organization was raised to a 2,000-bed facility.

The 142nd General Hospital was one of only two hospitals in the Southeast Asia Command (the other was the 20th General Hospital) that met the two prerequisites to perform radiotherapy in a U.S. Army hospital: a radiotherapist certified by the American Board of Radiology and an accurately calibrated x-ray machine.

The unit worked in Calcutta until January 1945, when the personnel began rotating home. However, the last did not leave until August of that year. The 142nd General Hospital cared for approximately 29,000 patients during its time overseas.

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CAPT. Edwin Nash Broyles, M.C., a 1919 graduate of The Johns Hopkins University School of Medicine, served aboard the Navy hospital ship U.S.S. Relief *during World War II. He was awarded the Navy Commendation Ribbon for meritorious service, as well as a Certificate of Merit from the Navy Bureau of Medicine and Surgery for his work in helping to develop Navy residency training program. Dr. Broyles was director of the Endoscopic Clinic at The Johns Hopkins Hospital that later was named for him. He died in 1977.*

JANE SHORT

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In 1943, Charles H. Williams, M.D., entered the U.S. Army Medical Corps and served one year as chief of the venereal disease service at Madigan General Hospital in Tacoma, Washington. Reassigned in 1944, Capt. Williams then served as chief of medicine aboard two Army hospital ships, the Dogwood *and the* Louis A. Milne, *transporting wounded patients from the Philippines to San Francisco. Each ship carried 12 physicians and 30 nurses, who cared for approximately 1,000 patients per trip. Most of the patients had been seriously wounded, but because the trip across the Pacific took approximately one month, some patients recovered by the time they reached the United States. Like other hospital ships, the* Milne, *a converted Liberty ship, and the* Dogwood, *a converted freighter, were painted white with a huge red cross. They traveled unarmed and brilliantly illuminated at night. The Army Medical Corps was in charge of the hospital, the Navy was in charge of the bridge, and the Merchant Marine was in charge of the engine room.*

A graduate of the University of Maryland School of Medicine, Dr. Williams is retired from the practice of internal medicine. He lives in Baltimore County.

MARY ANN AYD

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THE 118TH GENERAL HOSPITAL

Marion Friedman, M.D.

. . . . . .

ON APRIL 20, 1942, PERSONNEL who had volunteered for Hopkins' 118th General Hospital left from Pennsylvania Station in Baltimore, the music of River Chambers Orchestra and the good wishes of friends and relatives ringing in their ears. The train took the group as far as Providence, Rhode Island, where they were transported by bus to Camp Edwards in Falmouth, Massachusetts.

When the unit left Baltimore, its personnel consisted of only medical officers and nurses. It had no military training other than occasional meetings and lectures. It had had neither active duty experience nor sustained, practical military indoctrination.

After about two weeks of basic training at Camp Edwards that included some inoculations, distribution of equipment, lectures, drills, and experience with the use of gas masks, the unit embarked by train across the country to await a ship at San Francisco for parts unknown. During the brief waiting period the unit was quartered at the Cow Palace; the officers stayed in the Palace Hotel. Personnel of Hopkins' 18th General Hospital had arrived in California three days earlier and were housed in an abandoned International Harvester building across the bay in Oakland. At the same time, the 42nd General Hospital from the University of Maryland was being housed at the dog track in San Francisco. While waiting, they were issued additional equipment and became well exposed to the "maddening red tape." Some nurses who had not yet obtained their uniforms had to receive them from another outfit whose departure had been delayed.

Despite the risks and inconveniences, many could retain their senses of humor. One soldier claimed that he had observed a mosquito peering into his shirt to determine the blood type inscribed on his dog tag.

On May 10, the 118th sailed from San Francisco harbor aboard the U.S. Army Transport *West Point*. By this time, the unit had its full complement of personnel, but they were still without military training. Shipboard conditions were crowded: three other affiliated general hospitals, a dozen station hospitals, and all their equipment were also being transported aboard the *West Point*. There were no lifeboat assignments or abandon-ship drills until the fourth day. The need for almost continuous messing and the prohibition against lights made instructional work almost impossible.

By mid-1942, the Axis powers occupied Norway, Denmark, Belgium, the Netherlands, France, most of central Europe, the Balkans, and Greece. They had invaded northern Africa, had been actively bombing Great Britain, and were deep into the Soviet Union. In the Pacific, the Japanese controlled a large part of Asia and were masters of Hong Kong, Manila, Malaya, Singapore, and the Netherlands Indies. Two days before the 118th left Camp Edwards for San Francisco, Corregidor had fallen, giving the enemy complete control of the Philippines. The Japanese had established a powerful air and naval base at Rabaul on New Britain Island, thus closing in on Australia from three directions. The first serious confrontation in which the United States showed significant strength, the Battle of the Coral Sea, was in progress when the 118th sailed from San Francisco. When the unit was sailing halfway between New Zealand and Australia, the Japanese had penetrated its furthest point; three Japanese submarines eluded the protective barriers and entered Sydney harbor. Unknown to our contingent, the United States won its first real victory at the Battle of Midway on the very day they arrived in Melbourne.

Nevertheless, the ship zigzagged unescorted across the Pacific, arriving safely on the twenty-first day at Wellington, New Zealand. After a brief stop, it continued to Melbourne, Australia, where the 118th debarked June 5, 16 days after leaving San Francisco.

These gypsies again took up a temporary residence outside Melbourne at the Zoological Gardens, which they renamed Camp Pell (the same location was also to act as a temporary transit point for the 42nd General Hospital). After about two weeks, they embarked by train for Sydney, Australia, the city that would be their home for several years. Although they had now arrived at the general location in which it was intended that they would operate, they were temporarily quartered at a race track until a more permanent site could be located and facilities constructed.

Lt. Col. Allan Dawson was named commanding officer. A graduate of Jefferson Medical College, he had been a member of the regular Army Medical Corps since 1916. Lt. Col. I. Ridgeway Trimble and Lt. Col. James Bordley, III, both from Hopkins, were appointed chiefs of surgery and medicine, respectively.

There was a period of discussion and maneuvering about the final location of their facility—close to Sydney or farther north. Before the arrival of the Americans, the Australians feared actual invasion; with the changing conditions, however, they felt more secure and were less willing to relinquish their more productive and desirable sites. They finally agreed to allow use of 350 beds at the Royal Prince Alfred Hospital, which was a teaching facility and the Americans' first choice, but the American personnel had to be housed elsewhere. Because the facility was not large enough to accommodate all the U.S. patients, the unit also took over an old resort hotel at Medlow Bath, some miles west of Sydney, which they converted to a 524-bed medical branch. A more permanent site ultimately was provided about 12 miles southwest of Sydney at Herne Bay. Built by the Allied Works Council under reverse lend-lease in consultation with the U.S. Supply Service, the compound comprised 490 one-story buildings on 260 acres and contained 5,250 beds. Military planning at that time provided for eleven beds per 1,000 troops.

On August 4, some 3½ months after the unit was activated, the first patients were admitted to Herne Bay: a group of 59 American soldiers from the Royal Prince Alfred Hospital, of whom 26 required surgery. The next day, another 27 patients were transferred from the Australian 113th General Hospital. Soon they were overrun by a large number of cases of jaundice produced by a bad batch of yellow fever vaccine that

resulted in pathology for up to six months after it was received. Further crowding resulted from many cases of asthma that apparently were produced by a local weed when U.S. fighting forces reached New Caledonia. In the first months, it was a struggle to receive adequate supplies, a hardship further complicated by the sinking of a vessel carrying much of the supplies for the unit. Eventually, however, about 90% of the equipment was salvaged.

The soldiers' heroism and acceptance was remarkable. Dr. Trimble reported seeing one of the men with an arm amputated at the shoulder and remarking, "Well, son, we owe you a lot." "No, you don't, sir," the injured soldier replied. "It was just a little tough luck."

For about a year, the 118th was the only U.S. Army hospital in New South Wales to care for Army, Navy, and Air Force patients. Although the work was primarily of the station hospital type, some combat wounded were received who had been cared for in Australian Army hospitals before the 118th became functional. Included were some Filipinos who had been brought out of the Philippines aboard the U.S.A.H.S. *Mactan,* the only hospital ship to leave the Philippines before their surrender. The next battle casualties came from Buna-Gona, New Guinea.

Active fighting north of Australia resulted in the loss of one Australian and three American cruisers. A destroyer picked up 450 of the 900 men. They were suffering from multiple shrapnel wounds as well as blast injuries involving the chest and abdomen.

Although the threat of actual invasion was now considered less likely, the possibility of serious air raids was real.



Aerial view of the 118th General Hospital at Herne Bay.
Photograph by U.S.A. Signal Corps, provided by The Alan Mason Chesney Medical Archives of The Johns Hopkins Medical Institutions. *Used with permission.*

As a result, slit trenches were dug to shelter ambulatory patients if it should become necessary.

As the battle for the Solomon Islands heated up, U.S. forces caught a number of Japanese ships in the harbor and sank them. American troops invading the Japanese positions on the island came upon a building with a large Red Cross on it. Assuming it was a Japanese hospital unit, they were preparing to bypass it when batteries at the rear of the structure opened fire and nurses came out with guns in hand, firing. The structure then had to be destroyed. Some of the enemy when captured refused to move as ordered and had to be shot. Apparently they had been indoctrinated to believe that if captured, they would be interrogated, tortured, and shot; many felt it was their duty to die to protect their god emperor.

When the 118th finally moved into its "permanent" quarters, 1,000 beds were immediately placed into service. That number gradually increased to 1,600 by the end of 1943; peak occupancy was 1,591 in October. As the war moved north during the first half of 1944, the census declined.

In September 1944, the unit was assigned to the 6th Army and instructed to start closing its existing facility, but was not told where it would be sent. On October 9, after 17 months at Herne Bay, they transferred their few remaining patients and began packing, crating, and dispatching 2,600 metric tons of supplies and equipment which, over a 10-day period, left by ship in 3 separate contingents. Before the last contingent sailed, they learned that the 6th Army had landed in the Philippines and was fighting its way inland on the island of Leyte. While their cargo proceeded by slow Liberty ships, they boarded the *War Hawk*, one of a fast naval convoy, and set sail for their now-obvious destination.

On the morning of November 18, with shots bursting over the horizon, the ship was maneuvered into position along what they called Orange Beach. Although they had been temporarily delayed by the firing, they were able to board their landing craft and reach the beach without injury. They proceeded northward to a previously designated area along a coastal road in a low-lying, partially swampy 35 acres of land that had been selected for the hospital. Because of heavy tropical storms, almost impassable roads, critical shortages of transportation, frequent enemy attacks, and delays in getting the unit's

Physicians of U.S. Army General Hospital 118

Commanding officer
- Col. James Bordley, III*
- Col. Roy Brown
- Col. Allan Dawson

Chiefs of medicine
- Col. James Bordley, III
- Lt. Col. Thomas McP. Brown
- Lt. Col. A. McGehee Harvey
- Lt. Col. Walter L. Winkenwerder

Chiefs of surgery
- Lt. Col. John E. Bordley
- Lt. Col. August F. Jonas, Jr.
- Lt. Col. I. Ridgeway Trimble**

Other personnel
- Lt. Col. J. Herman Long***
- Lt. Col. John Whitridge
- Maj. George O. Eaton****
- Maj. Whitmer B. Firor
- Maj. William E. Grose
- Maj. Paul A. Kunkel
- Maj. William C. Stifler*****
- Maj. William B. VandeGrift
- Maj. Harold E.C. Zheutlin
- Capt. George A. Berkheimer
- Capt. F. Tremaine Billings
- Capt. Morgan Cutts
- Capt. Dougls G. Carroll, Jr.
- Capt. Edward Davens
- Capt. Daniel L. Doherty, Jr.
- Capt. Henry M. Fox
- Capt. Jerome D. Frank
- Capt. Robert A. Goodwin
- Capt. Thurston Harrison
- Capt. Donald C. Hooker, Jr.
- Capt. H.L. Johnston
- Capt. Lawrence Katzenstein
- Capt. Charles O. McCauley
- Capt. William T. Moore
- Capt. Edward T. Newell, Jr.
- Capt. Fred M. Reese
- Capt. Marshall C. Sanford
- Capt. George M. Shriver, Jr.
- Capt. Harris B. Shumacker, Jr.
- Capt. Joseph M. Tighe
- Lt. William R. Bethea, Jr.
- Lt. Wilbur Burton
- Lt. Richard D. Bush
- Lt. Hendrik DeKruif
- Lt. David A. Dolowitz
- Lt. John S. Hunt
- Lt. William N. Jones
- Lt. Eugene D. Lyon
- Lt. Victor E. Nicklas
- Lt. Roy A. Prediger
- Lt. Lewis C. Toomey, Jr.
- Lt. John B. Tredway
- Lt. Allan B. Warren

* *Awarded a Bronze Star.*

** *Later chief surgeon of Southwest Pacific area forces.*

*** *Awarded a Bronze Star.*

**** *Later orthopedic consultant for the Southwest Pacific Area.*

***** *Awarded a Bronze Star and also a Purple Heart for wounds received while on temporary duty in Manila.*

cargo ashore from the Liberty ships docked about 10 miles down the coast, acceptable care could hardly be provided. Nevertheless, the need for hospital care was so critical that they were ordered to accept patients in makeshift facilities. On December 12, they officially admitted their first 293 patients. It was almost one month before all their supplies and equipment were available to them.

With the help of Filipinos, the Army engineers worked feverishly to construct—mostly of long tents—an acceptable field hospital that included water and electrical supplies, latrines, operating rooms, canteens, and other amenities. Through March 1945, 7,677 patients (average daily admission, 77) were admitted from Leyte and other Philippine islands. Most of the patients were transported by air. By May, the hospital's capacity was increased to 1,800, but the actual peak census, reached April through June, was 1,550 to 1,625. Occupancy then started to decline, but it remained at more than 1,000 until September, one month after the atomic bombs were dropped in Japan.

During its days in Sydney, when the unit was enjoying the relative comforts and amenities provided by that area, it became known as the "Fighting 1-1-8." The name stuck. Although the unit was never in the thick of fighting, the name was more appropriate at Leyte.

The unit received many commendations from both Australian and U.S. officials. It earned battle honors for campaigns in New Guinea and the southern Philippines. In December 1950, the Department of the Army awarded it the Philippines Presidential Unit Citation for its achievements during the period October 17, 1944, to July 4, 1945. Some individuals also received military citations and awards.

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BEFORE the end of 1940, civilian professional organizations in the medical field were becoming involved in the process of recruiting medical officers and nurses for the Army. During World War I, the American Medical Association and the state medical societies had participated in the recruitment of medical officers. In June 1940, the AMA created a 10-member Committee on Medical Preparedness, which undertook a survey of the U.S. medical profession at the request of the Surgeon General of the Army. The Medical and Chirurgical Faculty of Maryland also had a Committee on Medical Preparedness, appointed in 1940 and chaired by Charles W. Maxson, M.D. Members of the advisory section included:

J. Albert Chatard, M.D., Baltimore
Frank J. Geraghty, M.D., Baltimore
Carroll Lockard, M.D., Baltimore
Richard T. Shackelford, M.D., Baltimore
Arthur M. Shipley, M.D., Baltimore
Harvey B. Stone, M.D., Baltimore
Edward P. Thomas, M.D., Baltimore
Walter D. Wise, M.D., Baltimore
Frederic V. Beitler, M.D., Baltimore
George E. Bennett, M.D., Baltimore
Alan M. Chesney, M.D., Baltimore
Thomas S. Cullen, M.D., Baltimore
Victor F. Cullen, M.D., Baltimore
Edward Ross Davies, M.D., Baltimore
John Staige Davis, M.D., Baltimore
J.M.T. Finney, Sr., M.D., Baltimore
William A. Fisher, M.D., Baltimore
Edgar B. Friedenwald, M.D., Baltimore
Cary B. Gamble, M.D., Baltimore
Arthur W. Hawkins, M.D., Baltimore
Frank B. Hines, M.D., Chestertown
Raymond Hussey, M.D., Baltimore
Amos R. Koontz, M.D., Baltimore
William D. Noble, M.D., Easton
John T. O'Mara, M.D., Baltimore
Maurice C. Pincoffs, M.D., Balitmore
Robert H. Riley, M.D., Baltimore
Lewis J. Rosenthal, M.D., Baltimore
Winford H. Smith, M.D., Baltimore
Henry M. Thomas, Jr., M.D., Baltimore
Huntington Williams, M.D., Baltimore
Peregrine Wroth, M.D., Hagerstown
H. Boyd Wylie, M.D., Baltimore
H.B. McCarthy, D.D.S., Baltimore

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Maj. William E. Grose, M.C.

One day about a year before the attack on Pearl Harbor, William E. Grose, then in his third year of surgical training at Hopkins, passed Dr. George G. Finney in a hospital hallway. "Hey, Bill, we'd like you to join the 18th," called Dr. Finney. With those simple words, Dr. Grose was recruited to serve in the war that appeared inevitable.

In the spring of 1942, married and with a 10-month-old son, he was called to active duty as a lieutenant with Hopkins' 118th General Hospital. Three weeks later, with approximately 30 other medical officers, 60 nurses, and 200 enlisted men who had been assigned to Camp Edwards in Falmouth, Massachusetts, Lt. Grose boarded a train bound for San Francisco. The train had no sleeping facilities and almost everyone developed respiratory infections.

After less than a week in San Francisco, the Hopkins unit boarded the former luxury liner America, converted to carry 5,000 instead of 1,000, and renamed the *West Point.* Aboard were all the physicians and nurses then available for the Pacific theater for the next two years. Their ship, reportedly the fastest passenger liner afloat, had been "disguised" with grey camouflage paint. As they left San Francisco, unescorted, they counted a half dozen docked battleships and cruisers—shockingly mangled from the bombing of Pearl Harbor.

They arrived in New Zealand 21 days later, stayed one day, then sailed on to Melbourne, Australia, where the physicians were housed in tents at the zoo. Lt. Grose's respiratory infection became bronchopneumonia and he was hospitalized until his group entrained for Sydney 10 days later.

In Sydney, the male officers initially were quartered at Randwick Race Course. They slept on cots in the ladies' unheated cloak room and made use of the facility's only other amenities: abundant toilets and washbowls. Everyone coughed terribly. Arriving at the onset of Australian winter and newly exposed to the germs of the southern hemisphere, they hung a sign proclaiming "Viruses Welcome." Thanks to the persuasive talents of Drs. Bordley and Trimble, however, the 118th was able to take over half the Royal Prince Alfred Hospital. By the time they were set up, casualties began arriving from the jungles of New Guinea.

Lt. Grose found it almost unbearable that the men were American soldiers. Having been engaged for days, weeks, months of horrible warfare in the coastal swamps of New Guinea, subjected to unknown bugs, reptiles, bacteria, and a desperate enemy under every bush, they arrived—hundreds per shipload—fevered, emaciated, hollow-eyed, expressionless, with dry lips and stinking wet bandages, legs eaten with jungle rot, suffering from malaria and dysentery. Those in the worst condition were restored to permit sea travel and sent back to the United States. But the command urged physicians not to send home anyone who, with rehabilitation, had a chance of returning to active duty.

Despite the grim periods, the physicians of the 118th enjoyed relative peace and hospitality in Sydney. At Hearne Bay, in addition to battle casualties, they cared for personnel passing through on R and R (rest and recuperation), as well as casualties from what Dr. Trimble called the "Battle of Sydney" (soldiers beating each other up). General MacArthur visited the hospital once, and so did First Lady Eleanor Roosevelt. Dr. Grose escorted her to lunch at one of the enlisted men's tables, finding her sincere and charming to everyone at

Shortly before the 118th arrived in Sydney, Japanese mini submarines (two men, lots of torpedoes) evaded the submarine net in Sydney harbor and shelled the town. When the subs never reappeared, the 118th became known as the "Saviors of Sydney."

the table and everyone she visited in the wards.

When MacArthur stepped ashore on Leyte (Philippines) in October 1944, the 118th received new orders. Their first stop was Hollandia, New Guinea, where they stayed four days in tents during a tropical storm. From there, they boarded a ferry and headed for the Philippines. Debarking on the same beach where MacArthur had landed a few weeks earlier, they were greeted by a Japanese strafer, but managed to "slog ashore" with no problem but apprehension. They were assigned to tents in a coconut grove bordering a river about a half mile from the beach at the Gulf of Samar. Although they were admonished ahead of time not to swim or wade in any standing body of water because of the risk of schistosomiasis (a severe public health problem throughout the Philippines), some enlisted men who ignored the warning contracted the disease.

Thanks to the tropical downpour, Lt. Grose saw only one memorable thing in Hollandia besides mud. On a hillside facing the harbor, an enormous billboard depicted a beautiful, shapely, young blond, wearing a low-cut dress, reclining on a divan, her index finger extended in a scolding gesture. The sign read, "Not until you take your Atabrine."

The Army Corps of Engineers built the 118th "a first class general hospital" in the coconut grove, which soon filled with casualties from the fighting on Leyte and neighboring islands. When the Americans invaded Luzon in January 1945, the 118th began taking in fresh casualties by air evacuation. "After a big battle, we worked day and night for several days in a row."

Although the hospital cared for thousands of patients on Leyte, the physicians managed to have a club built by native workers on the hill behind headquarters. Made of logs held together with roping, it was an enclosed structure with a plank floor and full decks front and back. From the rear deck they could see five to ten miles of geometric rice paddies, and beyond, the mountains and sunset. The front deck overlooked the Gulf of Samar, where lay at anchor "the greatest accumulation of warships in the history of the world." The evening it was announced that the Japanese had surrendered, they saw "a huge display of fireworks" as the hundreds of American warships fired every gun in celebration. Grand as was the news of surrender, the early description of the atomic bomb effects led Lt. Grose to

"Schistosomiasis japonica, a disease due to a parasitic worm, Schistosoma japonicum, is found in large areas of China, in a few foci in Japan, and on four of the larger islands of the Philippines. . . . When the cercariae (larval forms) escape from the infected snails into fresh water, as in ricefields, swamps, or ponds, they seek a susceptible host and either penetrate this host or die in from 24 to 48 hours. If the water drains into a river, the cercariae may be swept down the stream and in its course find their susceptible host. After burrowing through the skin, and migrating through the bloodstream and the lungs, they lodge at a later stage of development in the liver. By crawling down the portal venous system, they arrive at the branches of the vessels leading from the large intestine or rectum. After fertilization of the female by the male which carried her in a groove of his body, the female deposits clumps of eggs within the terminal branches of the vessels or in the liver. The embryo develops to a miracidium inside the eggshell. If this egg works its way through the intestinal mucosa, it is extruded in the feces and the miracidium hatches. The miracidium penetrates susceptible snails (if available) and in several weeks develops into a cystlike stage which has within it many cercariae. Thus, an increase in eggs takes place in the definitive host (man, dog, or other appropriate animal), and an increase in the cercariae occurs within the snail."

Bang BF, Billings FT Jr. Schistosomiasis japonica. In: Anderson RC, Havens WP Jr, eds. *Medical Department, United States Army. Internal Medicine in World War II.* Vol. III. Infectious Diseases and General Medicine. Washington, DC: Office of the Surgeon General, Department of the Army; 1968:91.

Ed. note: Frederick B. Bang, M.C., A.U.S., was consultant to the Secretary of War, Commission on Bacillary Dysentery, 1942-1943; and officer-in-charge of the Malaria Research Unit (Philippines), 1943-1946. At the time the above was written, he was professor and chairman of the department of pathobiology at The Johns Hopkins University School of Hygiene and Public Health and an associate professor of medicine at the medical school.

opine that the world itself would be blown up in ten years.

Shipped via Navy transport back to San Francisco ("the promised land for everyone who had been in the Pacific"), then-Maj. Grose immediately called his wife, but had to wait four days for orders to join her in Pasadena. He wired Dr. Blalock at Hopkins, who wired back that he could be chief resident surgeon if he could get to Baltimore by the end of next week. Replying that he had not seen his wife in almost four years, Dr. Grose asked if he could please have another week. Dr. Blalock answered that he could have as much time as he wanted, but if he wanted to be chief resident, he would have to be in Baltimore by the end of next week.

He was.

Now retired from the practice and teaching of surgery, Dr. Grose lives in Baltimore, where he enjoys tending a lovely ornamental garden that includes such edible delights as raspberries, elderberries, and blueberries.

MARY ANN AYD

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Reprinted from Coates JB Jr, Hoff EC eds. *Medical Department, United States Army. Preventive Medicine in World War II. Communicable Diseases Transmitted Through Contact or By Unknown Means.* Vol. V. Washington, DC: Office of the Surgeon General, Department of the Army; 1960:70.

"MEDICAL equipment being shipped to the Pacific is prepared at U.S. Army Medical Depot M-424, Honeybourne, England, the largest depot of its kind in England. Everything from delicate surgical instruments to x-ray machines is processed at this depot. Some 2,500 items are included in a so-called medical unit, which is sent as freight and does not accompany the hospital personnel. Certain surgical instruments require considerable time to prepare for shipment. A forceps, for example, gets a brisk cleaning in water, is dipped into carbon tetrachloride solution and is dried again. Then a technician, wearing rubber gloves, dips it again into a menthol solution to remove finger prints. After the forceps is dried it is covered with an oil preservative, then wrapped in aluminum foil and finally hermetically sealed in cellophane. Thousands of individual surgical instruments require this treatment.

"Major Charles A. Bohan, who is in charge of receiving and checking equipment at this depot, stated that bulky machines are torn down to save shipping space. If an item is damaged or rusted it is thrown into the salvage pile or 'cannibalized' for good parts. Pacific bound hospitals will only use American equipment. British items turned in to the depot are declared surplus, with future disposition to be made by the Army's general purchasing agent."

JAMA 1945;128:885

A View from Australia

Frances H. Trimble, M.D., M.P.H.

That fifty years, half a century, have passed, is a sobering reflection, whether one is measuring time in terms of international events such as V-E Day and V-J Day, or personal memories of a wedding in 1945 that led me to the United States.

I was born and grew up in Sydney, Australia. My mother was a nurse; my father was a master mariner, marine surveyor, and ship's pilot. By elementary school, I knew I wanted to go to medical school. I enrolled in Sydney University Medical School at the age of 17. The year was 1936.

During the preclinical years, I lived at home, in the suburb of Wahroonga on the north shore of Sydney, commuting by train and tram to classes at Newtown. I studied during the long commute and at home. After I helped my mother with the dinner dishes, I would stretch out my textbooks on my father's brightly lit billiard table and study until bedtime. About one fourth of my fellow students were women, but there were no women faculty members.

As we advanced into the clinical years, the political changes in Europe began to affect our lives. Lecturers and hospital attending physicians volunteered for the Australian armed forces. World War II began for us in 1939, when Germany invaded Poland. The war in Europe spread quickly to the Mediterranean and the Middle East. The Japanese, who had previously invaded China, quickly occupied the Philippines, Malaya, Singapore, and the Dutch East Indies. There was an exodus of doctors and medical personnel for service in the Middle East, Malaya, Singapore, and later in New Guinea. Ocean liners, such as the *Queen Mary* and the *Queen Elizabeth*, which had been converted into troop ships, became common sights in Sydney Harbor.

As a medical student, I was assigned to the Royal Prince Alfred Hospital, which had 1,000 beds, and the Royal Hospital for Women, which had 200 beds. Following graduation in 1941, I became a house officer rotating through both

hospitals. My training included a rotating internship that included medicine, surgery, and pediatrics; a year of anatomic and clinical pathology; then a year of obstetrics and gynecology. While I was at Prince Alfred, the "Joint Acting Superintendents" were two medical refugees: Professor Shellshear, a professor of anatomy who had escaped from Hong Kong, and Dr. Bearblock, formerly of the British Colonial Service, who had fled from Kuala Lumpur. Their method of silencing house officers impatient with scut work was to threaten sending them to the "Kokoda Trail," a "Death Alley" in New Guinea infamous for Japanese snipers, malaria, and dengue fever.

Heavy wooden beams were installed in all the Sydney hospitals to provide reinforcement against possible air raid attacks. Weekly air raid drills were held at night. Although Sydney never had air raid attacks, Darwin, the Australian city closest to the Japanese front, suffered more than a hundred, with damage to hospitals and loss of life in the community. There was also a submarine attack; three midget submarines managed to penetrate the submarine barrier of Sydney Harbor. They were able to inflict some naval damage though no lives were lost. In the days of panic after the attack, however, some who lived near Sydney Harbor anxiously sold their property to move farther inland.

> "At noon I looked out of my office door and there was Ridge with Al Blalock–Ridge looking extremely thin, with hair almost shaved off and a curious yellow-black color, but very well set up and military, with a sleeve full of hashmarks. I was certainly glad to see him.... He was feted in the dining room by everyone. ... As he and Warde Allan and Al Blalock and I were talking in the Osler 5 hall, along came Capt. Phil Tumulty, just flown in from Assam–looking not at all yellow or older, except that his hair is either bleached (Fiji Island sun?) or actually white. ... Others are all on their way home, some by boat and some by plane, according to chance, he says. So soon we will be overflowing with 18th Gen. Hospital on leave."
>
> Caroline Bedell Thomas, M.D., in a letter to Col. Henry M. Thomas, Jr., M.C., dated January 26, 1945.

At Prince Alfred we were required to keep half our beds empty for possible air raid casualties.

When the U.S. Army 118th General Hospital, formed of Johns Hopkins staff, arrived in Sydney in 1942, temporary quarters were arranged in tents at Randwick Racetrack. Soon, however, high-level negotiations between the leadership of Prince Alfred and that of the 118th General Hospital resulted in the transfer of our 500 empty beds, as well as a new neurosurgical building with operating rooms, to the Hopkins medical unit. Living accommodations were made available to medical and support personnel in neighboring residential colleges, a new multistory women's hospital (King George V), and the nearby Children's Hospital. When the 118th unit moved in, the Prince Alfred administration gave a welcoming party at which I met my future husband, Dr. I. Ridgeway Trimble, and other doctors and nurses who were to become good friends.

Civilian doctors, both recent graduates and those in practice, were placed under the direction of a committee of well-respected members of the profession, many of whom had served in the Australian armed forces in World War I. Their mandate was to see that the supply of doctors, stretched thin by the departure of so many medical graduates for military service, was effectively distributed to provide care for the civilian population. Only one to two years of hospital training was permitted for those going into the armed services. For the first time, women physicians were in demand for hospital positions as house officers in the major teaching hospitals. I and my fellow female medical graduates would not have been considered for the prized positions as house officers at the Royal Prince Alfred Hospital and the Royal Hospital for Women in the prewar years. Senior women received hospital appointments for which they might have otherwise waited years. Two of my favorite young instructors, Dr. Lee Day and Dr. Jean Armytage (the daughter of my role model, Dr. Lillian Pope), took over running the department of pathology at Prince Alfred. My year in their lab, livened by their good humor and unassuming

competence, comprised some of the happiest times of my training.

After three years as a house officer, I and many of my fellow women medical graduates spent the remainder of the war years doing *locum tenens* of two to four weeks duration for overworked general practitioners. Our assignments were chiefly in rural areas where doctors were scarce and patients scattered. Our official journeys to and from our posts were almost the only travel available to us. By train, I was able to see a lot of my home state, New South Wales, as far south as the border with Victoria and as far north as the Queensland border. During my *locum*, I saw patients in office hours, made house calls, delivered babies, and tended to minor injuries. Between assignments, I would return home to Sydney for a few days of rest and relaxation with my family. During these years two of my brothers were in the Royal Australian Navy, and one was in the merchant marine; all were in and out of war zones in different parts of the world. The war was never far away, brought home by newspapers, radio, newsreels at the movies, and censored letters from family and friends in the armed forces.

Ridge Trimble, to whom I was then engaged to be married, was promoted from the head of surgery in the 118th General Hospital to chief surgical consultant to General Douglas MacArthur, first in Brisbane, then New Guinea, and then the Philippines. He was in the United States planning for the projected invasion of Japan when V-J Day occurred. He received special leave to fly to Sydney, where we were married on September 15, 1945. I continued to work in the mandated *locum tenens* program until my father found me passage as ship's surgeon on a freighter bound for New York. The voyage from Sydney to New York, through the Panama Canal, took six weeks. I landed in New York April 6, 1946. I still carry the "green card" issued to me that day.

Ridge encouraged me to continue my medical interests. Under the expert tutelage of Dr. Nicholson Eastman and his associate, Dr. Eleanor Delfs, I studied for the state medical board examinations during the first of my three pregnancies. Thanks to the support of Drs. A. McGehee Harvey and James Bordley, I did not repeat any house staff training in this country. I was granted my medical license in 1947.

Ed. note: Now retired, Dr. Trimble is the former medical director of Planned Parenthood. She lives in Baltimore. ■

A COUNCIL on medical care has been created by authority vested in the [Maryland] state board of health by act of the 1945 session of the general assembly to provide consultation and advice in connection with the program to be administered by the newly established bureau of medical services. The following have been chosen members of the council to represent the organizations indicated:

Dr. Page C. Jett, Medical and Chirurgical Faculty of Maryland.
Dr. Earle Paul Knotts, Medical and Chirurgical Faculty of Maryland.
Dr. Jacob W. Bird, state board of health.
A.G. DuMez, Maryland Pharmaceutical Association.
Dr. James Douglass Shepperd, Maryland Medical Association.
F. Noel Smith, Maryland State Dental Association.
P.J. McMillin, Maryland District of Columbia Hospital Association.
Dorothy F. McBride, Maryland State Nurses Association.
Dr. Alan M. Chesney, Johns Hopkins University School of Medicine.
Dr. George Carroll Lockard, University of Maryland School of Medicine and College of Physicians and Surgeons
Dr. Robert H. Riley, director of the state department of health.
Dr. George H. Preston, state commissioner of mental hygiene.
Dr. Victor F. Cullen, superintendent of Maryland state tuberculosis sanatoriums.
J. Milton Patterson, director of the state department of welfare.

Dr. Dean W. Roberts, chief of the bureau of child hygiene of the state department of health, was appointed chief of the bureau of medical services, which will administer a program furnishing medical care for indigent and medically indigent persons and will conduct and operate the chronic disease hospitals to be constructed in the postwar period.

JAMA 1945;128:604.

LESSONS OF THE PACIFIC FIGHTING

Col. I. Ridgeway Trimble, M.C.

Chief of Surgical Service, 118th General Hospital, 1942-1944; and Chief Consultant in Surgery, Army Forces Western Pacific and Army Forces Pacific, 1944-1946.

Certain conclusions set down by the surgical consultant in the Southwest Pacific Area after his return to civilian life may be summarized as follows:

1. It is strange that such an obvious principle as that of early and expert definitive surgical care was not automatically adopted at the beginning of World War II, when experts in the various surgical specialties joined the Army in such great numbers. It was slow to be adopted in the Southwest Pacific Area, chiefly because the value of the consultant system was slow to be realized. Consultants were assigned to headquarters in the smallest possible numbers. There were no consultants to the armies operating in the Southwest Pacific until after the landings in Leyte, in October 1944. The surgical consultant in the Southwest Pacific Area was permitted to participate in the attack on Leyte but was refused permission to accompany the transports in the attack on Luzon. More intimate contacts between theater and Army consultants and surgeons would have enhanced the efficiency of medical care of casualties.
2. At the beginning of the war, there were only a handful of expertly trained clinical surgeons in the Regular U.S. Army. To the end of the war, there was still a scattered lack of appreciation of the difference between a medical officer *designated* to do surgery and a medical officer *trained* to do surgery. In the Pacific, at least, there was only slow realization of the extreme importance of the wisdom of sending experienced surgeons of mature judgment into forward areas and assigning younger, less experienced surgeons to base hospitals, where they could work under supervision.

Throughout the entire Pacific duty of the 118th General Hospital, its ingenuity, imagination, and emphasis on prevention benefited not only its own personnel, but others as well, including civilians. Dr. Trimble's redesign of plans for constructing the hospital was not only accepted by those in authority, but incorporated into plans for future units. He also noted the unusual number of burn cases due to burning the brush with gasoline. He determined that if discarded, already-used oil was substituted for the gasoline, the fires were more easily controlled and fewer troops were burned. General Douglas MacArthur's office circulated this information to all the units under his command.



Lt. Col. I Ridgeway Trimble, M.C., wearing captured Japanese vest. Reprinted from Coates JB Jr, Beyer JC, eds. *Medical Department, United States Army. Wound Ballistics.* Washington, DC: Office of the Surgeon General, Department of the Army; 1962:686.

Perhaps the most significant innovation was the result of Dr. Trimble's learning that a protective vest had been seen on a Japanese prisoner. Dr. Trimble refused to rest until he had seen it—no small accomplishment because he soon learned that there was only one vest, and the U.S. command would not release it. Eventually able to view it, he arranged to have it studied so that it could be reproduced and improved. Nevertheless, it was not easy to interest those in authority. Having finally obtained agreement that the details for this innovative piece of equipment would be forwarded to Washington for consideration, the information was lost in transit. Not until the war was almost over did Washington send 8,000 vests to the Pacific as a demonstration, having manufactured 100,000 and having accumulated materials to produce another 800,000 if the device proved as beneficial as it appeared. We can only guess how many lives would have been saved and how much disability avoided had Dr. Trimble's suggestion been accepted when first presented. Before the 118th left the Pacific area, an enterprising Australian attempted to patent the vest in his name, but was prevented from doing so. The protective vest used by law enforcement personnel today had its origins here.

MARION FRIEDMAN, M.D.

Source: Archives of the Johns Hopkins Medical Institutions. World War II collection; Trimble papers, boxes 7 and 8.

3. The chief duty of the surgical consultant in the Southwest Pacific Area was the assignment of good surgeons to serve as chiefs of surgery in the portable hospitals supporting the various landings. This was an extremely difficult task because of the paucity of well-trained surgeons in the Pacific; practically all of them were sent to the Mediterranean and European theaters, or were in the Zone of Interior.

4. The vast distances in the Pacific greatly complicated medical care of casualties. Sometimes 2,600 miles separated the target area and the point from which an operation was mounted. In hops to small, isolated islands, there was no such thing as a chain of evacuation. Definitive surgical care had to be given on the spot. Specialized hospitals were accepted as a practical possibility only after the Philippine invasions.

5. Distances in the Pacific also made communication extremely difficult. Brig. Gen. Elliott C. Cutler, MC, Chief Consultant in Surgery, Office of the Chief Surgeon, European Theater of Operations, U.S. Army, stated that he could sit at his desk at headquarters in London and within a few minutes reach by telephone the commanding officer of any hospital in England or on the Continent. In the Pacific, even radio communication was not possible, and most business had to be conducted by mail. Attempts to transfer medical officers might take a month or more. A visit by plane to hospitals in the various bases might take a minimum of 2 weeks, partly because of waiting for priorities and the vagaries of the weather; the visit itself was likely to consume the smallest part of the time period.

6. Evacuation of casualties in the Pacific fighting was always a problem. Portable surgical hospitals were sometimes miles ahead of the artillery pieces going into the jungle. The hospitals would follow the infantry and set up a few hundred yards from the enemy. Evacuation was a necessarily complicated process. It was first by litter, sometimes borne by natives but more often by Army litter bearers because the natives did not like to go forward. Then native litter bearers would take over later. Sometimes, evacuation was by ox-drawn cart or by amphibious vehicle.

   Air evacuation, which was an outstanding success and solved many of the problems of transportation in the Pacific, came late in the war.

7. Surgical teams were proposed very early in the Pacific fighting by Colonel Parsons, first Consultant in Surgery in the area, but the plan was not accepted until April 1944. Auxiliary surgical groups never served in the Pacific; all of them were sent to the Mediterranean or European theaters. Portable surgical hospitals helped to solve the problems of forward care of casualties but did not prove an entirely acceptable solution. Specialized hospitals, as already mentioned, were not permitted until the Philippines were invaded and never really fulfilled their possibilities.

8. The difficulties of surgical care of casualties in the climate, terrain, and vast distances of the Pacific areas were probably never fully realized in the Office of The Surgeon General because there were no really intimate contacts between the office and the Pacific. The single visit, during the course of the hardest fighting, was by the Consultant in Surgery in that office and was very brief. The only other visit, by The Surgeon General, was also brief and did not occur until after the Philippines had been almost secured.

9. The difficulties under which medical care was accomplished in the Pacific are unlikely to occur again. For one thing, the value of the consultant system is now fully appreciated in the Medical Department of the Army and is firmly established in it. For another, the Medical Department has set up residencies in its largest hospitals in the various specialties and is thus assured of a supply of fully trained medical officers in the event of another emergency.

10. Far and away the most valuable surgical lesson learned by the U.S. Army Medical Corps during World War II was not the use of penicillin, or of large quantities of whole blood, or of evacuation by air of the wounded—great as these advances were. The most valuable lesson was the realization of the validity of the concept, well known to all trained surgeons, and also learned and then forgotten by the Medical Corps after World War I, that the mortality and morbidity of combat casualties can be reduced to a minimum only when mature, highly trained surgeons are available in forward areas of combat.

The consultant's own experiences, both triumphs and disappointments, and the similar experiences of others, bear out this concept. Any acceptable plans for surgical support of future operations must follow the same principle. If any plans contain even the possibility of delay on the availability of immediate, definitive surgical care by surgical experts, they should be discarded forthwith.

Reprinted from: Coates JB Jr, Carter BN, McFetridge EM, eds. *Surgery in World War II. Activities of Surgical Consultants.* Vol. II. Washington, DC: Office of the Surgeon General; 1964:755-757.

Ed. note: Dr. Trimble died in 1979. ■

DR. CHARLES E. Funk, editor of the Funk & Wagnalls dictionaries, is quoted as saying that the word penicillin should be pronounced "pen-i-ci´l-lin." He writes that he entered this pronunciation in 1942 after consulting with the New York Academy of Medicine, The American Chemical Society, and Professor Fleming, the English scientist who discovered penicillin and gave it its name. The pronunciation "pen-iss´-il-in" has not been accepted.

Venereal Disease Information 1945;25:212.

Battalion Surgeon in the South Pacific

Maj. George Sharpe, M.C.

We marched to the dock, 141 of us, 13 officers and 128 enlisted men, with khakis and full field packs, our helmet liners giving some shelter from the hot San Francisco spring sun approaching the high noon. It was March 22, 1944, and we were leaving the United States from Camp Stoneman, California, to finally actively join the war in the Pacific. I was occupied by thoughts of the future, over which I now seemed to have apparently lost control. When would I be reunited with my little family? Alison, my bride, and Jeanette, our nine-month-old baby. The thought was accompanied by a wave of poignant loneliness so strong that I felt a pang akin to grief. Then, the question: would I come back?

My thoughts became more optimistic as I contemplated our imaginary war map of March 1944. The Allies had pushed back the Nazis and Italians in Africa or on the Italian peninsula, with Italy technically surrendered. In the Pacific Ocean, we had made slow and painful progress pushing back the Japanese to the northern and western areas of New Guinea and had retaken some central Pacific islands. *Maybe we'll be back before we see any fighting. Perhaps the European war will end this year and Japan will give up.*

The trip across took six weeks. The beauty of the sea, the flying fishes, porpoises, and the constant alerts became routine. No meaningful work occupied our time. As a medical officer, I was assigned duty to hold periodic sick calls in the ship's hold, but within the first half hour of the first duty, it became an impossibility for me to hold anything down in the hold and my dignity became lost to the overwhelming force of nausea.

For the most part, we saw only the sea and its denizens until one morning in April, after more than four weeks, we wakened to the sight of a green mass

arising in a haze far ahead of us. We watched with eager anticipation as we learned that this was New Guinea, our destination. We learned that a "big operation" along the coast of Papua, New Guinea, was to take place. However, the 608th was not going to take part, as they "didn't know what to do with us yet." Our trip continued along the coast for another two days, and we found ourselves at Finschhaven Harbor. Our area would be used as an auxiliary base of operations as the Nimitz-MacArthur strategy of "leapfrogging" the enemy's bases on New Guinea was becoming apparent.

Jerry died at 1100 on September 16, 1944. I knew I had lost my best friend in New Guinea. They buried him the same night at a cemetery on the base, and the next day we held a graveside service. Prior to that day, I associated the bugle call taps with the good times of various boys camps, or routine ceremonies on Armistice Day, or nightly at army posts. But after hearing taps at Jerry's funeral, its meaning changed and became more and more pronounced as the war progressed. To this day, on hearing those notes, even in a fragmentary manner such as in a news broadcast, I feel completely torn apart.

The first few days on New Guinea were absorbing because of the newness of the experience and the work involved in just getting settled in. I became responsible for sanitation and immediately recognized that although our site was a beautiful one, the area was just covered with flies. Immediately I put my men and myself to work spreading oil and digging ditches.

Whatever we learned of tropical diseases was accomplished on our own with no concerted effort on anyone's part to organize the medical officers into discussion groups. The most prevalent disease was dengue fever, a self-limiting disease that can make one feel awfully uncomfortable for about three weeks. They told us that malaria was not as prevalent as you might suspect, but everybody was taking Atabrine everyday to suppress the disease. Japanese scrub typhus was rare in our area. By July 10, 1944, something like five percent of our unit was incapacitated by dengue fever, including some of the officers, including me.

August 2, 1944, became a very important date in my life when, out of the clear blue sky, the mail brought me orders to report to the 6th Infantry Division. I would travel with my unit to Sansapor, where the 6th had just landed to join the division there. There was no ceremony involved in starting this assignment. Theoretically, there were supposed to be ten medical officers assigned to the clearing company, but we had very sick patients and it seemed to me that every day I saw new faces making rounds and then disappearing.

In addition to the omnipresent scrub typhus, we were seeing various primary pneumonias (bacterial and viral in origin), yaws, dysentery, urinary tract infections, parasitic infections, malaria, hepatitis, and other fevers. Interestingly enough, of all the medical officers that I came in contact with, none had had any training in tropical medicine, even though the Army Medical Center in Washington, D.C., had one of the best review courses in the world. I had applied and was told that being sent there for a two-week or three-month course might give the *enemy* ideas as to where my unit (a small, separate clearing company) might be sent! Instead, I was sent to Edgewood Arsenal in Maryland for one month to learn about chemical and gas warfare.

We were kept busy day and night. We couldn't rely on laboratory or x-ray routinely, so I reviewed and perfected my acumen in physical diagnosis. We were frustrated by our basic helplessness. The mycins were not yet available. Five years later, Chloromycetin and Aureomycin were known almost as cures if started early enough.

During this time, I used penicillin for the first time. I had used the sulfa drugs in the last part of medical school, and now we used them for selective infections and prevention of complications of wounds. Penicillin was a miracle to me. I watched a young man sick unto death one night with lobar pneumonia the next morning ask for breakfast after two doses of 300,00 units each every four hours.

By the end of September 1944, it was apparent that the Philippine Islands would be the next main objective of the United States forces. Sansapor was now a secure base, with all of the field amenities available for staging an invasion force. The 6th Division was being held in reserve as back-up for the Palau Islands and the Philippine Islands.

In December, we plunged into frenetic activity to get prepared for our invasion of Luzon. On December 24, we ran a rehearsal of a ship-to-shore landing. On December 25 we ate turkey with all the trimmings on shore. The next day we completed our loading despite the heavy surf of up to fifteen feet in height. We were right on schedule Christmas night.

I had no regret at leaving so-called "peaceful New Guinea" for the unknown. I had seen a little combat and seen enough of its effects to realize the horrors of war. There were some very uncomfortable physical interludes during my stay there; boredom, at first, was the worst of my enemies, and I had now tasted the pain of losing young men who were close to me.

We left Sansapor on December 29, 1944, to join forces with Allied naval units, combat divisions, and supply vessels coming from New Guinea, Australia, Hawaii, and the mainland U.S. It was the largest invasion force ever assembled and certainly one with the longest potential supply line in history. For the most part, we were oblivious to the cost in men and ships responsible for our safe conduct through enemy waters. The Navy and the Coast Guard suffered more than 1,800 casualties including more than 700 dead; 24 ships were sunk and 65 damaged, some severely, before the landing was completed and 175,000 GIs were safely ashore at Lingayen Gulf.

> By the end of January the men of the 20th Infantry were feeling almost ecstatic. Looking at the map, we could see enormous progress into the heart of Luzon at relatively little cost. We had lost a total of 81 dead and 198 wounded or injured throughout the entire division. Most of my medical duties had centered around groups of civilians, routine sick call of GIs and, at most, an occasional man wounded on patrol or in a vehicular accident. We began to believe that we were a favored group, chosen to lead the victorious march into Manila. What a dream: to spend the rest of the war as an occupying force in a friendly, civilized, relatively undamaged city!

On January 10, I felt as though I was going to take an important exam. The boat struck the beach and we plunged forward in water up to our waists. The beach was deserted, not a sign of life. Our front line troops were already away in. There was hardly a tree undamaged by the bombardment. It must have been horrible.

Our immediate objective was to secure the eastern flank of the central plains by occupying a town called Munoz. As we came over a slight rise we could see the town of Munoz. Insofar as we could see, it looked very quiet.

Colonel Van Sickle held a meeting of staff and company commanders. "Headquarters says that one company should occupy Munoz. Intelligence says that Munoz is empty of enemy activity! I'm calling for artillery to drop shells on the roads leading into town tonight in case the Japs decide to send defenders back. The place looked too quiet to me for its location since it controls access to San Jose, the gateway to the mountains, as well as communications to the south on the whole eastern front of Luzon down to Manila."

"Van," I interjected, "we're set up in that little draw up over there about fifty yards away if that's okay with you. We have assured ourselves of communications with the clearing company and collecting company, and we have an ambulance from B company in that grove of trees. I told my men to set up for about forty-eight hours."

"Good, Doc. I'm not worried about your guys."

It's still in my mind—the beginning of the second day. Two GIs, guns strapped to their shoulders, carried him in. Their hands formed a chair. God, but he was gray. His black beard framed the gray grimace that formed his face. The eyes were shining with an unnatural light. I could see his blood-stained fatigue jacket torn open in the lower right front. His

> I can say now that war is a more horrible fact in retrospect than it ever is in anticipation. My respect for the human body and mind is considerably increased. The tortures that man endures under the circumstances is beyond conception. Even though our life in the aid stations is not easy physically and hard on me mentally and emotionally, the assault troops up forward are really to be pitied and make us all feel thankful for our fortunate situation.
>
> George Sharpe, in a letter to his wife dated February 4, 1945.

bearers laid him gently on the litter that served as my "examining table." It lay across a hole so that I could sit on the edge with my feet under the litter.

The sun was shining hot and ruthlessly down on the scene. He was in shock and life was ebbing as the blood-stain grew larger. One of my men started plasma. I dipped my hands into the bichloride of mercury solution in my helmet after tearing away the jacket and ripping open the torn belt line. There was a jagged, four-inch hole in the lower right quadrant of his abdomen just above the groin. Blood was bubbling out. I tried to sponge away the blood, but it was coming too fast. Remembering my anatomy, I blindly felt for the source. It had to be an artery. The larger arteries felt intact, but I got a glimpse of the recurrent epigastric spurting blood. Thank God I could handle this with hemostats and packing. The flood of blood began to slow down so that I could further examine the field and satisfy myself that the bleeding was further controlled with pressure bandages. We could stabilize him with plasma and get him back to the evac hospital for some definitive surgery.

I saw Joe Zerr, aid man, race past the body with the top of its head blown off—helmet spattered with blood, and brain tissue lying neatly by as a silent open mouth gaped pleadingly to heaven. Another sudden death, we thought.

The familiar piercing cry of "Medic!" from behind stopped him. He turned to see one of the riflemen kneeling by the corpse, which was now thrashing its arms and legs in a desperate swimming motion. "My God, it's alive," I thought as he ran and kneeled by the other GI's side. The litter bearers brought it to me in the twilight.

"Into the ambulance!" I shouted, and followed the litter in. The door shut behind me so I could work under blackout conditions. The occipital lobe was gone—the back of the brain. He'll never see, I thought. The surface of the remaining corpus was bleeding. Brain was spilling out over the hard protective remains of skull. I packed as much of brain back with a crude abdominal dressing, started plasma, and consciously prayed that the living corpse, a friend of mine in life, would die before the next moment passed. At best, he would be a soulless, blind vegetable if he lived.

I opened the ambulance door and fell out exhausted into the twilight. Tears were pouring down my face and I sensed hysteria for the first time in my life. Reality was gone. The ground upon which I fell offered a comfort—something solid. Maj. Frank Linnell lifted me up and I could see his tears and felt the warmth of his empathy as we clasped each other closely and slowly made our way back to the aid station. No words were exchanged, but the moment was embedded into my soul forever.

I asked the collecting company for extra litter bearers and on February 2, eight rugged young men appeared with the first relief ambulance. I was too busy to ask them personal questions and assumed they were combat veterans. I sent one group of four out forward about 10:00. To my everlasting horror, three were dead within minutes. The four were sent as one team into a fierce firefight taking place about 200 to

Black humor was a different kind of life saver. During one horrendous bombardment one of the men wondered aloud how long we could take the constant fear and panic of Munoz. "Cheer up, we'll soon be dead," answered another. We all felt better after that.

300 yards in front of our position. Reports were coming back of an enemy pillbox and a buried tank camouflaged with hay that were holding up L Company with heavy fire. Several casualties were lying out in the open. A smoke shell was dropped and the litter team went out under its protection. The smoke lifted and only one man escaped with his life when a machine gun nearby mowed down the squad before the group could perform its function.

> We have set a new record for days in constant combat with the enemy, well over two months. Most of the outfits have always been able to get rest, but even in our so-called rest periods, parts of us were under strain patrolling enemy territory. Excepting for a couple of nights in the hospital, I haven't had my clothes off to sleep since we landed. The others haven't had even that respite. I've had a couple of close calls, but I thank God they were unusual and I am still alive and well. Those poor fellows in the line companies are continually having close calls.
>
> George Sharpe, in a letter to his wife dated March 15, 1945.

During the afternoon of February 5, a tremendous wind blew in from town. Many haystacks had been set afire, and the wind was carrying lighted torches over the road into areas near us. One dropped on the roof of the house we had been using for shelter from the sun whenever possible. All of us dashed around to remove whoever was in there awaiting transport to the rear. General Patrick, commander of the 6th Infantry, came down to see "why in hell the 20th hadn't moved more than a few hundred yards into town." As Van was explaining how his forces had been deployed, there was a sudden blast of noise, a blend of all the weapons available to the enemy. Overhead we heard the whish and whine of shells and bullets. All dignity was gone as we tumbled down to the ground, hearing the general say, "I see what you mean, gentlemen." We later learned that we had been up against an armored division representing the largest concentration of Japanese armor faced by the United States in the Pacific war.

Our battalion left Munoz under strength but overwhelmed with individual nightmarish memories of the past week and mutual grief and concern for those dead and wounded left behind. Our immediate mission was to set up roadblocks at crossroads to prevent enemy movements between the two largest forces left on Luzon. The battalion was going to be scattered over a considerable distance. Headquarters, including our aid station, would be set up in a small village called Bongabon, where the people thus far had suffered relatively little when compared to some areas. Our battalion then received orders to move south. After almost a two-day march by truck and on foot, we finally arrived and viewed the imposing row of mountains in front of us. The Shimbu Line, it was called. We were facing more than 14,000 well-trained, well-supplied, well-prepared enemy troops charged with keeping the water supply reservoirs for Manila and Luzon from falling into American hands. General Shezuo had spent many months preparing defensive positions on many of the peaks and wooded draws. The only route of approach to each row of hills lay across successive flat ricefields open to observation.

> *It's late afternoon and the battle is over with. I went into the town that had been our objective and saw not a building standing. The stench of dead bodies was sickening. There was no indication that a beautiful little city once stood here.*
>
> George Sharpe, in a letter to his wife dated February 7, 1945.

We took up positions just east of Quezon City. By February 20, I had established my aid station in a substantial stone house. The night of February 24 and the early morning hours of the next day disappeared from my life because, when I awoke, I was barely able to move due to a fever and weakness accompanied by severe vomiting of blood. My men rolled me onto a litter, put me in an ambulance, and sent me back to the field hospital. By February 28, I felt well enough to go back on duty.

Our companies were scattered throughout the area. I would be requested to stay with one of the companies

periodically. Almost every night I was in a different location. Even though I felt well protected at sunset in the perimeters of the various companies, it was a horrendous feeling each night in the dark to hear the approaching gunfire on all sides and realize that we were isolated from our main body. The nights were long and filled with terror.

I can still recall the feeling—a terrible noise associated with a cold, stinging numbness surging through my body. I fell to the ground with a vision of dirt and debris arising from the hole into which two men had rolled just as I was about ten yards away, ready to jump in. My hesitation saved me from joining them. I was visibly shaken as the shelling continued. The enemy had zeroed in on this draw with their mortars and artillery. The faces of the two men in front of me were intact, but their chests and abdomens were obliterated—emergence into the dust of death sooner than is usual. They were from the heavy mortar platoon assigned to our battalion.

It was almost one year since I had come overseas. The day of the week had lost its meaning. All of us now were starting to feel some fatigue, even though our morale was still high. Every day that went by, more and more Japanese were being killed at a lower and lower cost to us. Our biggest concern now was whether the rainy season would take place before we wound up the most important parts of the campaign to complete security of the reservoir.

John Keim called me back to regimental headquarters on March 17 to be his assistant. Part of my duties entailed moving forward and relieving some of the battalion surgeons whenever they needed a rest or assistance. Our division general, Maj. Gen. Edwin J. Patrick, was killed during an ambush in this area as he traveled from one outpost to another.

At regimental headquarters, John Keim and I had cots to sleep on in a hole four feet deep by ten feet long which had solid sandbag walls and a roof. Occasionally, I had a chance to get into Manila. The city itself was in absolute ruins, except on the periphery where the scars of war were not as visible. Poverty and starvation were present all over. The actual fighting had taken place literally from room to room in almost every building in the central part of the city and had completely left rubble in place of the beautiful old city dating back to Spanish times. The stench of dead bodies was still present. Sanitation had broken down to the point that it was miraculous that we hadn't seen epidemics of cholera ravaging the population. We knew that dysentery was present there.

Outside of the city, the scenery was absolutely beautiful. The roads were paved within a reasonable radius of the city. There were small enterprising stands selling souvenirs and food at very high prices. It was a schizophrenic existence to go from the field of battle and, within one hour or two, back into a recognizable civilization.

About April 10, it became apparent that the 20th was not the fighting force it had been. Our ranks were decimated. One company could muster only twenty-six men. Some platoons were down to eleven men. On April 15, we mourned the death of President Roosevelt. The next day, we received news that the remains of the 20th were going to Manila to take over military police duties in the city.

The newspapers at home had referred to our efforts as "mop-up" operations the past few weeks. Even though the Shimbu Line is not to be found in any atlas that I have ever seen, it is etched forever on the minds of all of us who crawled over it.

I had until June 5 to meet the regimental headquarters at San Jose, just north of Munoz at the opening of the Balette

As chief medical officer on a troop ship bound for the Pacific through the Panama Canal, Capt. Manuel Levin, M.C., examined a soldier with a high fever and stiff neck that turned out to be meningiococcal meningitis. The ship had to return to port, where it stayed almost a week while all the men were treated with sulfadiazine. Again under way, minus the one sick soldier, the ship headed for Australia. Capt. Levin received three Bronze Stars for campaigns in New Guinea, the Bismarck Archipelago, and the southern Philippines. He marched with a unit on Luzon that followed Gen. MacArthur to Manila. With an air warning unit at the airport, he worked with other physicians to examine arriving casualties—up to 200 at a time—for triage.

Still in practice as an internist, Dr. Levin goes to his office at Sinai Hospital of Baltimore four days a week.

Mary Ann Ayd

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Levin M. Telephone interview, September 11, 1995. ■

Pass to the Sierra Madre Mountains east, and the Cordillera Central Mountains to the west. Our division had orders to replace the 25th and 37th divisions that were busy racing northward toward Aparri at the northern tip of Luzon. We were destined to face General Yamashita, the Tiger of Malay, while other troops were to regroup in preparation for the final onslaught against the Japanese homeland. It was sunset when we arrived at our new camp.

The 2nd Battalion was spread out through the mountains, sending out patrols daily and killing Japanese at a rapid rate. Prisoners of war were still coming in, some in small groups. There were occasional wounded to be cared for, and the lines back from the rugged mountains were long. We hired some of the natives in the area at fifty centavos per day to haul supplies up and litters back. Some of the trails were so narrow that coughing could send one over the side. With our loads on our backs as we moved forward, we clung as close to the walls of the stony cliffs as we could. Sometimes hundreds of feet below we could see the river running through the valleys. It was the rainy season, so my first foxhole was dug into the mud again and all I could think of was now, instead of a reptilian who had lived on land for eons, I had regressed into the antediluvian era as an amphibian who spent most of his time crawling in the mud.

In addition to the mud, the flies and other bugs had become quite pesky. It was a very low point in my life; I felt as though I had failed in my career, my family didn't seem to care for me anymore, and I was in a totally hopeless situation. Even our position in the war seemed to be totally unappreciated, as General MacArthur had announced on July 1 that the Phillippines campaign was over with. We were to continue with the "mopping up" operation. To the individual GI, this didn't mean much of a change—there was still a very formidable enemy around us. Our situation insofar as living was concerned was certainly going to become worse as we looked at the terrain in front of us.

One comforting procedure that was used during this period of July and August was pulling us out periodically from the mountains to a more permanent bivouac in the lower area. Up until this point, rather than indulging in self-pity for having been assigned to the Southwest Pacific, many of the GIs looked upon the Italian campaign as being the most forgotten and that the GIs there suffered the most in every way, from terrain, weather, and neglect. In one of our periods of rest, a couple of replacements who had served in Italy for a few months and then were transferred to the Southwest Pacific made the remark, "This place if full of sh--! We wouldn't put mad dogs in Italy into quarters that they give us here!"

At 0800 on August 15, 1945, the President issued his proclamation and then we received the news. The division artillery radio crackled and tersely quoted the President's statement, and then issued orders, "Cease all hostilities at 0830—do not fire unless fired upon. All patrols will hold their positions."

I returned to the U.S. by slow boat to join Alison and Jeanette, then two and a half, for Thanksgiving Day dinner in November 1945. While sitting on the sofa, I watched Jeanette ignore me and play with a doll. Suddenly, she came up to her mother, pointed at me, and asked, "Is that my daddy?"

Ed. Note: Retired from the practice of medicine in 1985, Dr. Sharpe lives in Kensington, Maryland. The above account is excerpted from Dr. Sharpe's book *Brothers Beyond Blood* published in 1989. *Used with permission.* To obtain a copy of the book, call 301-942-0444. ■

In 1943, Leo P. Hennigan finished undergraduate work at the University of Scranton and had been accepted at Georgetown University medical school. He was inducted into the U.S. Army instead, trained in the Medical Corps as an aid man, then shipped to New Guinea in 1944 with a medical battalion of the 6th Infantry Division. By January, the Americans finally were poised to invade Luzon, in the Philippine Islands. On January 8, 1945, Cpl. Hennigan heard Tokyo Rose deliver a special message to the 6th Infantry: "We know you're landing tomorrow. We have a nice welcome planned for you." Despite the heavy kamikaze raids and the determined Japanese ground resistance, Cpl. Hennigan eventually returned to Georgetown, where he obtained his medical degree in 1950. A practicing psychiatrist, Dr. Hennigan lives in Chevy Chase, Maryland.

Mary Ann Ayd

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Maj. Eli M. Lippman, M.C.

A member of the Reserve Officers Training Corps as an undergraduate at The Johns Hopkins University, Eli M. Lippman was a second lieutenant in the U.S. Army Infantry in 1936. He earned his medical degree at Long Island College of Medicine in 1940 and had completed a surgical mixed internship at Brookdale Hospital in New York City when he was called to active duty in September 1941. Transferred to the Medical Corps because he was a physician, he was then ordered to the 5th Armored Division at Fort Knox, Kentucky. From there, he was sent to motor mechanics school in Detroit ("I was very good") and returned to his motor battalion after the attack on Pearl Harbor. In 1942, he was sent to Oakland, California, where he began serving as a physician, helping with the induction examinations of 1,500 boys a day.

Later that year, he was transferred to Maui, Hawaiian Islands, to a hospital built using a group of Japanese-American laborers who eventually became the 100th regiment, one of the most decorated in the Army.

In November 1943, then-Capt. Lippman boarded the U.S.S. *Belle Grove*, headed for the Gilbert Islands. With the invasion forces, he landed on Makin, a tiny, T-shaped island about 25 yards wide at the stem and perhaps three miles long at the crossbar. Japanese troops were holding the island in trees and log trenches. With three physicians and a dentist, Capt. Lippman established an aid station on the beach. There they could do little more than "throw sulfa into wounds," tag the casualties, and evacuate them back to the ship. The battle for the island lasted four days.

By June 1944, the Americans were ready to launch Operation Forager in the Marianna Islands. Assigned to Central Pacific Base Command, Capt. Lippman landed on Saipan, where the two-week battle for the island cost 25,000 Japanese lives and 3,500 Marine deaths and casualties. It was not until he arrived on Okinawa in the spring of 1945, however, that he saw how large was the American armada of ships arrayed against the enemy. Again, he landed with invasion forces, which encountered no immediate resistance. He did see two Japanese sitting on the beach. One, spotting the red cross on Capt. Lippman's armband, said, in English, "I'm a photographer." The men were Japanese, however, not Americans.

The Americans took control of the airport almost immediately, but the Japanese still controlled the southern part of the island and the high ground. Capt. Lippman had a somewhat larger aid station than those he had had on Makin and Saipan. At first he had relatively little

AWARD OF THE SOLDIER'S MEDAL: By direction of the President, under the provisions of the Act of Congress approved 2 July 1926 (Bulletin No. 8, WD, 1926), and pursuant to authority in AR 600-45, 22 September 1943, a Soldier's Medal is awarded by the Commanding General, Army Service Command, APO 331, to the following named officer:

Captain ELI MORTON LIPPMAN, 0349555, Medical Corps, Army of the United States. For heroism displayed in rescuing an enlisted man from drowning at Okinawa, Ryukyus Islands on 22 August 1945. While he was swimming in the water at a nearby beach, he noticed a man floundering in the water about 200 yards distant. With complete disregard for his personal safety, Captain LIPPMAN swam out toward the drowning man, and towed him to safety where he administered first aid and delivered him to a nearby hospital. His act reflects great credit upon himself and the military service.

to do and treated only minimal wounds. It was not long, however, before serious casualties from this, the costliest battle of the Pacific war, began to arrive. When the all-night Japanese air raids began, he and others took shelter in some of Okinawa's underground mausoleums, which in many places the Japanese were also using as defensive strongholds. As the battle for the island dragged on, Capt. Lippman began to notice fewer and fewer Japanese planes. He also saw a remarkable increase in the number of surrendering Japanese soldiers—one night they had 800—and concluded that even the Japanese knew their defeat was inevitable. When he learned that a new, deadly American weapon resulted in Japan's capitulation, he thought its use was unnecessary, that Japan was already on the brink of surrender.

For his service during the war, Capt. Lippman was awarded the American Defense Medal, Combat Medical Officer's Medal, Asiatic Pacific Medal with Four Stars (with invasion forces in the Gilbert Islands, Saipan, Okinawa), World War II Medal, and Soldier's Medal. He returned to the United States, a physician with no medical license, seeking a residency in orthopedic surgery ("that was all I knew"). His odyssey took him first to the Veterans Hospital in Fayetteville, North Carolina; then to Duke University, where he passed the medical boards but was unable to obtain a residency; to Halloran General Hospital on Staten Island, New York; to Portland, Maine, for a year; then back to the U.S. Marine Hospital on Staten Island, where he finally was able to finish his residency. A former chief of orthopedic surgery at the U.S. Marine and Franklin Square hospitals in Baltimore, he still maintains a private practice in Baltimore.

MARY ANN AYD

On Okinawa in mid-September 1945, about 600 freed American prisoners of war ate only Red Cross-provided candy bars for two days because food ran out on the chow line before the men, including former Olympic track star Louis Zamperini, reached the kitchen. The mess sergeant would tell them to try again at the next meal. Visiting Capt. Lippman for a routine medical checkup, Zamperini mentioned the conditions on the chow line. When Capt. Lippman got in line with the men at the next meal, the food ran out again and they were told to come back at breakfast. "That doctor was like a wild man when that happened," Zamperini told an NBC reporter. "He grabbed me by the arm and said the first thing he wanted to do was get some food in me. On the way to his mess, he stopped every officer—no matter what rank—and told them what was happening and demanded action." The next day, work began on another mess kitchen.

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A RADIO series of coast broadcasts over the Columbia Broadcasting System entitled "The Doctor Fights" will begin Tuesday, June 5. Motion picture stars will participate in the dramatization of such events as the heroic three days in July last year, when Capt. James E.T. Hopkins, M.C., treated 80 casualties during the battle for the Munda air strip on the Solomon Islands, and other similar case histories from actual service files. The broadcasts are being presented by Schenley Laboratories, Inc., and will consist of thirteen dramatizations. Whenever possible the programs will be cut in from Washington and other points to introduce the doctors of medicine whose stories are being dramatized.

JAMA 1945;128:379.

On Okinawa

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Capt. Joseph M. Miller, M.C.

Following service in the Zone of Interior, I was sent to the Pacific Theater of Operations. We were aboard an unescorted transport out of Seattle, Washington, and anchored briefly off the Marshall Islands and then Ulithi, where we were allowed to leave the ship. The weather was great that Sunday afternoon, and I wandered by myself down to the south shore of the island. The beach was wonderful; I could look right out into the Pacific Ocean. I had started to look for seashells when I suddenly became aware that I was not alone. I looked to my left and there was an octopus of some size. I do not know who was more scared, but we went in opposite directions at the same time. My seashell hunt was abruptly terminated and I returned to the ship.

HEADQUARTERS
75TH FIELD HOSPITAL
APO 180

28 August 1945

201.22

SUBJECT: Letter of Commendation
TO: Major Joseph M Miller, Commanding Officer 401st Medical Thoracic Surgical Detachment, APO 902

1. Your and your team are to be commended for the excellent job done on our surgical service during your stay with us.
2. My regards to you personally and thanks for your cooperation.

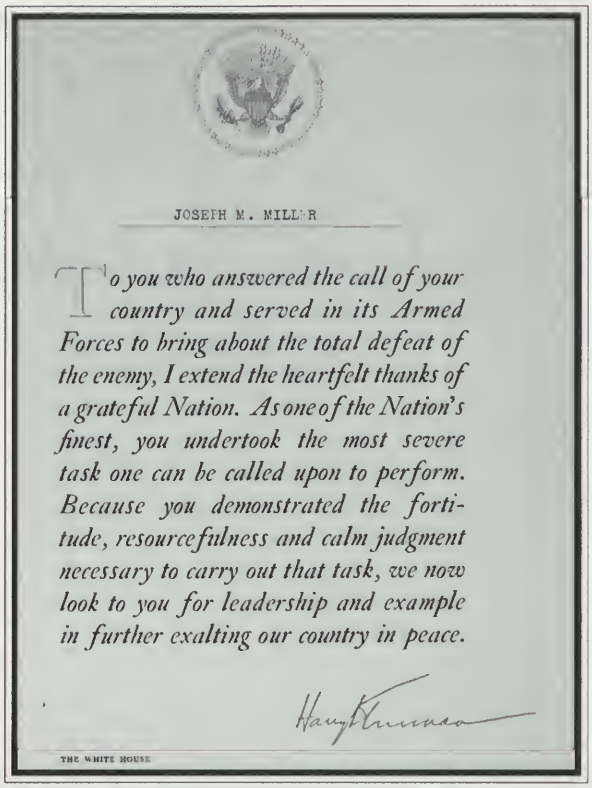
[signed] Joseph L. Diamond,
Lt Col, Med Corps,
Commanding

At Ulithi, we had the opportunity to see "Washing Machine Charlie." He came up at sunrise everyday from Yap, still held by the Japanese, on a reconnaissance mission.

I had another scare as we were debarking onto a lighter at

Okinawa when one of the little planes the Japanese were flying appeared over the convoy. I never did see what happened as we safely made for the shore as quickly as possible.

I was in charge of one of the first M.A.S.H. units activated, although such groups would not be known by that name until the Korean War. Surgical aid was sent far forward to render operative treatment as soon as possible after injury. We were an independent team attached to a station hospital for rations and quarters. We were located on the coast of the East China Sea just above Naha near Shuri Castle.



JOSEPH M. MILLER

To you who answered the call of your country and served in its Armed Forces to bring about the total defeat of the enemy, I extend the heartfelt thanks of a grateful Nation. As one of the Nation's finest, you undertook the most severe task one can be called upon to perform. Because you demonstrated the fortitude, resourcefulness and calm judgment necessary to carry out that task, we now look to you for leadership and example in further exalting our country in peace.

Harry Truman

THE WHITE HOUSE

As the commanding officer of my small group, I was issued a Colt caliber 0.45 for use, if necessary. All medical personnel were given guns for protection inasmuch as wearing a red cross did not stop a bullet. I had great difficulty with this gun and gladly swapped it with my first sergeant for a 13-shot carbine, which was a dandy rifle. This I could aim and shoot with greater ease.

On Okinawa, we found that the use of parachute nylon to cover raw wounds was much kinder to the tissues than ordinary cotton gauze. I recall getting a discarded parachute to obtain the material.

After the cessation of warfare there, we were being prepared for the Olympic invasion of Honshu envisioned for November 1945. On night in August, any number of handguns were fired into the air and scuttlebutt was that the Japanese had surrendered and the war was over. We then heard talk of some sort of bomb that had been dropped twice on Japan and that they wanted to stop the war. It is difficult to put into words the joy which appeared everywhere on the island. We were going home to see our loved ones at last!

Such was not to be, however. The 401st Medical Thoracic Surgical Detachment was detoured to Korea to accept the surrender of the Japanese army there.

Ed. Note: Now retired from the practice of surgery, Dr. Miller lives in Timonium, Maryland. ■

From November 1940 to August 1945, an estimated 17,954,500 men were examined for induction into military service. Of these, 6,419,700 were rejected, but it would appear that at least two more should have been. While in Trinidad, Col. John B. De Hoff, M.C., encountered a former Linotype operator, about 38 years of age, who suffered from a symptom-free chronic duodenal ulcer. He told the draft board about his condition and repeated his story for the examining physicians at induction. "Don't worry," they replied, "the Army will do your ulcer good." On the way to Trinidad to complete basic training, he became severely seasick and his repeated vomiting ended in hematemesis. Arriving at the Port of Spain hospital with a hematocrit of about 14, he was assured of air transport back to the States, probably with a prompt discharge from the service. On the other side of the world, Maj. William E. Grose, M.C., encountered a young black soldier evacuated from New Guinea because he was blind. In fact, he had been blind since birth. Having undergone a "quickie" induction physical, he had been helped and led around by his buddies from Mississippi to New Guinea before his blindness was recognized and responded to.

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MEMORIES OF WARTIME

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Hiroshi Nakazawa, M.D.

The war is on!

Of course, I will never forget that day—the seventh of December, 1941. I was in the fourth grade and just ten years old. My father had already been called by the Japanese army to report to Taiwan in October of that year to prepare for "something big coming," so in a way, we knew that war would break out soon. That day, my mother woke us up to listen to the seven a.m. broadcast that repeated loudly that our Imperial Army and Navy had entered the war against the United States and Great Britain in the Western Pacific Territories. The Japanese navy had attacked Pearl Harbor and destroyed most of the U.S. Pacific fleet in the air raid.

In our ignorance, we all celebrated this big triumph, and when we went to school that day we could not sit still to listen to our teachers because we were all so excited by the news of our initial victory. The principal of our grammar school gathered all of the students from the first to sixth grades together and gave us a pep talk. He said that Japan had tolerated the interference of big western powers such as the United States and Great Britain for too many years. America had opposed Japan's invasion of China and they had terminated all oil exports to Japan.

Our principal reminded us that even though we were a small country, we had "Yamato-damashii"—meaning that the Japanese people had a persistent spirit. Under the emperor, who was descended from god, he said, we could win all the way. Emperor Hirohito's declaration of war against the western powers was announced and followed by Prime Minister Hideki Tojo's feverish speech asking all Japanese to unite behind the military in this war, which he called a holy war against injustice and oppression by the western countries.

Before he left home for the war, my father asked me to take charge and share the responsibility for the well-being of my three sisters and two brothers with my mother, since I was his firstborn son. He told me that I must help my mother, who worked hard as an ophthalmologist in the industrial city of Takasaki, our

hometown, situated 150 miles northwest of Tokyo. My father, a medical practitioner, had been called upon by the army just a few years earlier, to serve from 1937 to 1939, in the North China operation, when Japan invaded China. This time, he was sent to South Taiwan, where he was ordered to set up a military medical corps with large-scale dispensaries. He told me that this time he may not return.

Our father, who was stationed in Manila in early 1942, sent us beautiful post cards. He was then sent to Rabaul, east of New Guinea in the New Britain Islands, in April 1942. Although he could tell us nothing about why he was sent there, we thought that perhaps it was because Japan was about to invade Australia.

At the beginning of the war, from 1941 to 1942, Japan won many battles and moved swiftly to the south, into Hong Kong, the Philippines, Malaysia, Singapore, and Indochina. We were jubilant in the first several months of the war at the news of our victories, coming one after the other. Young students from the seventh grade and up underwent special military training programs to help them develop into future soldiers. We all came to believe that we must be willing to die for our emperor and for our country. We were constantly reminded that Japan had never lost a war in our 2600-year history. Failure would not begin with us.

Many junior high school students entered special training schools to become officers in the army and navy. I myself wanted to become a naval officer, both to serve my country and because the Japanese navy was thought to be formidable and fearless. We did not see at the time that the people of Japan were, in a way, being slowly brainwashed.

Meanwhile, news of several severe losses by the Japanese army was completely concealed from the Japanese public. By that time, unbeknown to us, Japan had already been raided by Lt. Col. Jimmy Doolittle, who had launched an air strike from the aircraft carrier *Hornet*. U.S. B-25s dropped bombs over Tokyo. This was the first time that Japan had *ever* been invaded by another country. Around the same time, the Japanese navy was defeated at the Battle of Midway by the U.S. fleet, and the Japanese people knew nothing of it.

As Japan moved further south into New Guinea and other areas in the South Pacific, we stopped hearing from our father altogether. After his last postcard from Rabaul, his whereabouts remained unknown. In the meantime, despite the constant broadcasts of our many victories, the people and the country as a whole began to show tremendous fatigue. We started to experience severe shortages in food, clothing, paper, and precious metals. We all had to collect iron scraps from our backyards and from the streets and carry them to the industrial park, so that the army would have more iron for manufacturing weapons. No luxury was allowed. For example, women were not permitted to wear their Japanese kimonos any longer. Instead, they were told to wear long pants. Precious metals and diamonds had to be given up to the army.

The United States took over the Saipan Islands in 1943. U.S. air raids by B-29s became more intense and routine. Many children and elderly people had to move away from the big cities to the countryside. Many people lost houses, but most importantly, they lost their fathers and brothers and sons. The repeated broadcasts of Japanese victories continued, and yet slowly they began to lose their persuasive power. The public had begun to feel the heavy casualties and losses at the war front too keenly.

In late 1942, our family received a telegram from army headquarters which stated that our father was missing in action on a South Pacific island—we did not know until much later that the name of that island was Guadalcanal. The news saddened and shocked all of us, and my mother went into a severe depression. I consoled my mother many times, and we swore to work together for our own survival while, at the same time, to do our best for our country.

In the summer of 1943, we received a shocking telegram dispatched from the port of Ujina in southwest Japan, near Hiroshima. It was from our father. It read, "I am safe and alive!" We children and even my mother jumped all around with joy. She left soon after to go to the Tokyo train station to meet my father's train. She was shocked to see trains full of Japanese soldiers crowding the platforms—all of them wounded, bandaged, starving, some bleeding, some diseased. She almost missed my father as he passed by her because he had become so emaciated. His weight had dropped from 225 to 130 pounds.

Our father limped in both legs due to compound fractures and gunshot wounds. He was also suffering from amoebic dysentery, malaria, malnutrition, and severe depression from the continuous strain of the air raid bombs. But he spoke well. Once he was home with us again, he began to tell us and our family friends about what had really happened on the island of Guadalcanal.

When the Japanese first landed on Guadalcanal, they made an airfield that was to serve as an intermediary base from which to strike Australia. But U.S. Marines immediately landed on the island and took over, chasing the Japanese troops into the jungle. The Japanese suffered heavy casualties because their medical supplies and food were all cut off by the U.S. air strikes, which utilized America's superior

artillery weapons. The U.S. had indisputable air supremacy. Japanese soldiers became ill and starved. Many died. My father had no medicine to combat their illnesses and the troops became hopeless.

He recalled to us that when he first landed on Guadalcanal, he thought it was the most beautiful island he had ever seen in his life. But that same day the heavy battle began, with many casualties on both sides. My father said he had seen both heaven and hell in one day. After that, he survived for six months until he was able to retreat, along with many other wounded men from the island, thanks to strategic Japanese naval tactics that took the troops, at night, back to Rabaul.

In Rabaul, my father gathered hundreds of the sick and wounded soldiers into a cargo ship, which was to be transported to Japan. No one was allowed to contact their families in any way, due to the constant U.S. intelligence surveillance and the threat of the U.S. reconnaissance planes. Even so, their cargo ship was hit by a U.S. submarine at the equator on its way to Palau island. Miraculously, my father survived again, this time treading water and floating in the ocean for fourteen hours along with other wounded soldiers. He and many others were saved by a Japanese destroyer from Palau island. He then returned to Japan by another ship which—in order to avoid U.S. submarine attacks—took almost six weeks to cross the ocean.

When my father came home, he told the truth about what had happened at the front. He thought that Japan could not win this war because the U.S. was too powerful. He told us and those in our community that we had nothing but fatigued spirits left to fight against U.S. offensives. When the military police heard of my father's speeches, they came to our home one night and warned him not to speak about anything that was happening at the war front anymore. My father decried this silencing: he was only telling the truth.

In 1944, Japan had already begun to prepare for future battles in our homeland. My father strongly advocated that we should all build home bomb shelters, which were unheard of. He also organized a neighborhood cooperative network to help us assist one another in the case of air raids, fires, and, of course, injuries and casualties.

In March 1945, 800 U.S. B-29 bombers raided the city of Tokyo with firebombs, resulting in 300,000 casualties. All so-called nonfighters were moved out from Tokyo to the country. Those in the seventh grade and up were taught to make and use spears from sharpened bamboo to fight against the U.S. soldiers. They also learned how to use grenades.

Of course, few Japanese children had had English lessons during our schooling, since it was the so-called enemy language. It was around this time that my father told me that if I were interested in following in his footsteps and studying medicine, I should learn English by private tutor. He said he met a few U.S. medical doctors while in prison in Manila and he thought, after many conversations with them, that "this U.S. medicine sounded promising." He himself had been trained by his professors in the German method, which was much less high tech. I challenged my father at that time, protesting to him that he was putting down Japan and dishonoring our country with such talk. I still could not conceive of Japan's defeat at that time.

My father told me that I should listen to him and not be afraid of the truth. This was perhaps the most important moment we ever shared as father and son, although I would not realize it for some time.

In August 1945, the atomic bombs were dropped on Hiroshima and Nagasaki. Russia declared war against Japan and began to invade Manchuria. Japan's defeat became evident and imminent. On August 14th, 1945, the Japanese Emperor came on the radio himself to declare that in accordance with the Potsdam Declaration, the Japanese had surrendered unconditionally to the Allied forces. This was the first time that any of us in Japan had heard the Emperor's own voice. Many people cried and were in despair. Some committed suicide. But our parents thought that perhaps a new era had just begun for the new generation.

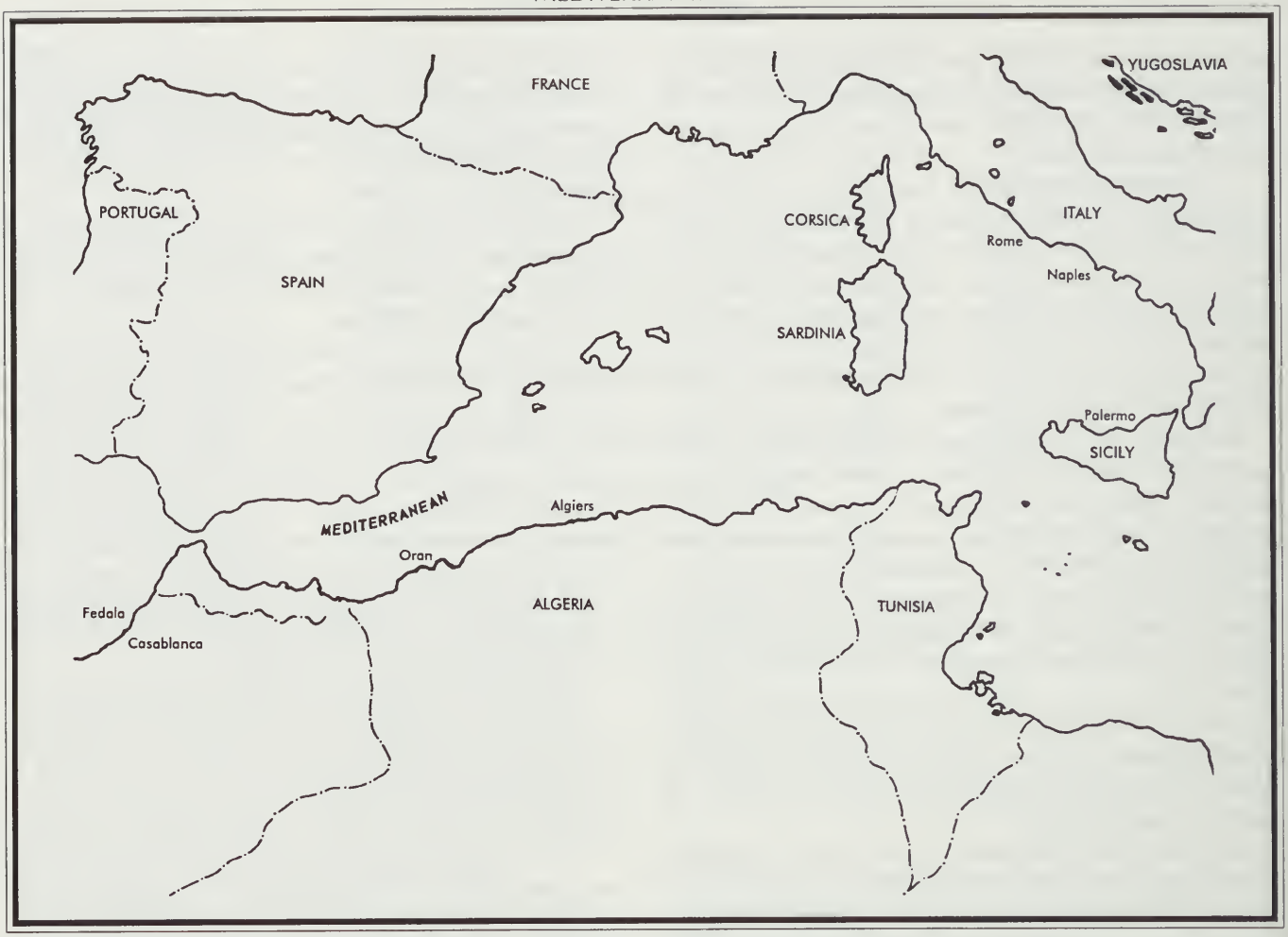
After the war, Japan was in chaos. Black markets flourished. Inflation wreaked havoc on the country. The emperor declared that he was no longer a divine descendent of God, he was merely human. He became visible to the people. Gen. Douglas MacArthur, Supreme Commander of the Allied Forces in Japan, began to perform the unbelievable task of reorganizing and rebuilding the country. He helped to restore our public trust and faith in ourselves. He supported the notion that the Emperor was human, yet he emphasized that he was still a great symbol to our nation, and that we must begin to work hard to rebuild our country.

My father purchased a farm for our family so that we could raise our own crops, such as rice and vegetables. He wanted to ensure that we would be independent and not be forced to buy inflated goods through the black market. As I worked beside my father in the fields of our farm, I learned that success only follows hard work. In the eighth and ninth grades, I had to both attend school and work the farm. Around this time I told my father that I had decided, yes, I wanted to become a doctor like both my parents. I began to study English, hoping that I would later be able to study medicine in the United States.

To this day, I have never forgotten the afternoon when my father told me how promising American medicine sounded. And it has never ceased to amaze me how much of my fate and my life today have hinged on that time in my life when, as a young man, I listened to the lessons of my father, a true survivor.

Ed. note: A past president of the Baltimore City Medical Society, Dr. Nakazawa is a general surgeon and medical acupuncturist. He lives in Baltimore. ■

THE
MEDITERRANEAN



Capt. H. Leonard Warres, M.C.

In January 1941, having just completed a two-year internship in New York, H. Leonard Warres, M.D., joined the Army for what he expected would be a one-year commitment. On December 7, he and his wife, Margie, whom he had not seen for several months, were enroute to her parents' home on the Eastern Shore of Delaware for a family gathering. They had much to discuss and drove with the radio off. Not wanting to ruin the evening, her parents stifled the news about Pearl Harbor until after dinner. Lt. Warres' one-year hitch would now extend to more than five.

During his first months in the Army, and despite his medical training, Lt. Warres was placed in charge of motor vehicles. Although the table of organization specified a medical battalion, medical officers frequently were assigned to bedsheets, parts, and other inappropriate duties. Not all assignments, however, were attributable to simple mismanagement. Lt. Warres crossed paths with a colonel who voiced to friends his intention to make every Jewish medical officer a battalion surgeon. The incident did spark an investigation, but the colonel suffered no repercussions.

"One of lessons quickly driven home in the Tunisia Campaign was that plasma was not a complete substitute for blood in combat surgery. No supply of whole blood was available, nor had any provision been made to fly it in. To meet the immediate and pressing need, an informal blood bank was established at the Gafsa section of the 48th Surgical Hospital, where 25 to 50 troops were detailed each day as donors. Out of the II Corps blood bank of 1943 grew the theater blood bank of 1944."

From: From: Wiltse CM. *United States Army in World War II. The Technical Services. The Medical Department: Medical Service in the Mediterranean and Minor Theaters.* Washington, DC: Office of the Chief of Military History, Department of the Army; 1965:144.

On their way to Fort Blanding, Lt. Warres and an advance group of medical officers were bivouacked at Fort Meade. Wanting to see his wife in Baltimore, but doubtful that he could obtain leave, Lt. Warres asked his commanding officer if he was familiar with the famous Baltimore night spot, the Oasis. Intrigued, the C.O. readily agreed to a quick sightseeing trip to Baltimore. Once he had safely guided the C.O. to the Oasis, however, Lt. Warres slipped out to meet Margie.

Lt. Warres was assigned to the 1st Infantry Division, "Big Red 1 at Fort Devens, Massachusetts." Eventually he was ordered to Carlisle, Pennsylvania, for combat officer training. Official battle plans were secret, but the men nevertheless knew they were training for the first Allied invasion in the European war. The wives knew it as well. Each morning, the married officers left their rented rooms toting all the personal gear they would need to ship out, and each morning the wives gathered together for breakfast and hoped that today would not be the day. When the inevitable orders came, the families received word that if they attempted to enter the base, they would be shot. Margie Warres alone ignored the order and, unmolested, was able to say a final goodbye to her husband in person.

The entire infantry division sailed unescorted to Scotland aboard the *Queen Mary*. Following a brief stay in England, they embarked for Operation Torch, the American-British invasion of North Africa that commenced November 8, 1942, with landings on the beaches of Morocco and Algeria. Enroute, a number of men stayed up all night shooting craps. Lt. Warres won all the money—so much that it overflowed his pockets. Having no use for it under the circumstances, he later sent it home to his wife.

The ship that transported Lt. Warres' unit was torpedoed after the men put ashore at Oran in then-French Algeria. Due to the stiff resistance of the Vichy French, it was three days before the Allies captured the city.

Along with a number of other Americans, Lt. Warres was then disattached from his unit and attached to British forces under the command of Field Marshal Bernard Mongtomery. Lt. Warres was invited to an observation point to witness the start of a desert battle against German forces commanded by Field Marshall Erwin Rommel. He heard only silence and saw only miles of apparently barren sand. The moment the British guns began firing, however, Arabs, goats, chickens, and other assorted creatures emerged frantically from the ground to escape the barrage.

Although the Germans bombed the area daily, Lt. Warres was invited to tea every afternoon with the British officers. Once when American troops were back from the front lines for delousing, which at that time involved fumigating clothes with gasoline, the Germans decided the moment was particularly opportune. Their bombs incinerated all the soldiers' uniforms, blankets, and other gear, and "we were a naked army for about five hours until the British found uniforms to lend us." The British eventually repaid the Germans in kind.

During the fighting in Tunisia, Gen. Lesley J. McNair, one of the U.S. Army's ground forces commanders, was wounded and in shock from loss of blood. Revived with intravenous fluids and other palliative care, he never forgot that Lt. Warres had saved his life. Later in the war, Lt. Warres was returned to Fort Dix as a patient. Gen. McNair contacted him there and asked him to come to Washington, D.C., when he was well. During the visit, Gen. McNair asked about his medical interests, which Lt. Warres indicated was radiology. "You've got it," the general responded. "I'm writing your orders now."

Amid the bitter and costly battle at the Kasserine Pass, Lt. Warres and his unit had to cross a bridge, one by one, under German fire. Here, Lt. Warres sustained his first battle injury, a serious but not incapacitating shrapnel wound to the ankle. Had he reported it, he would have received a Purple Heart.

While in North Africa, Gen. George Patton, commander of the Western Task Force for Operation Torch, visited a hospital where he publicly berated a wounded 1st Division soldier for cowardice. Lt. Warres was among those later privileged to hear Gen. Patton's forced public apology for the incident.

The Allies' North African campaigns secured the toehold needed to launch their next invasion. On July 10, 1943, Lt. Warres, now assigned to the

"*There is nothing rigid about the field medical service. . . . The job . . . is to get a man to surgery with the least possible delay consistent with keeping him alive. The battalion surgeon will probably not change the dressings the company aidman has applied, but will administer more plasma and perhaps morphine if the man shows signs of returning to consciousness. The wound will be immobilized so far as its location permits to minimize the shock of further transportation, additional entries will be made on the EMT [Emergency Medical Tag], and the patient will be speeded on the next stage of his journey. His destination now will be the clearing station of his division, located five to ten miles behind the front, and the field hospital set up adjacent to it specifically for forward surgery. When he leaves the battalion aid station he will pass from first to second echelon medical service—from regimental to divisional control.*"

From: Wiltse CM. *United States Army in World War II. The Technical Services. The Medical Department: Medical Service in the Mediterranean and Minor Theaters.* Washington, DC: Office of the Chief of Military History, Department of the Army; 1965:3.

16th Infantry Regiment of the 1st Division, landed in Sicily. A German bomb skipped over his landing craft and detonated on the other side. The first job was to dig in for protection from German artillery. Apparently dissatisfied with the effects produced by ammunition alone, however, German tanks rolled onto the beaches to crush the foxholes and their occupants. Later assigned to the 5th Field Artillery, Lt. Warres was promoted to captain. He suffered permanent hearing damage (also not reported).

The Americans pushed forward. At one point, low on ammunition, those at the front dispatched a truck back to the landing site for a new supply. Speeding past Gen. Patton's car, the driver failed to salute and was promptly detained for an angry, half-hour lecture on military protocol. Once Palermo was secured, Capt. Warres learned there were still missiles to be dodged. Only by walking very close to buildings was he reasonably safe from the Sicilians' habit of tossing garbage out the window.

Throughout the North African and Sicilian campaigns, carrying a .45 pistol and what amounted to little more than a first aid kit, Capt. Warres followed the infantry into battle. As battalion surgeon, he manned the battalion aid station, a location that moved with the battle, several hundred yards to the rear. There he patched up the wounded as much as possible and tagged them for the medical collecting company, the next stage in the treatment chain. In addition to the constant danger, the job was frustrating because there was so little he could really do to treat casualties. He functioned primarily as a paramedic.

With Sicily eventually secured, Capt. Warres was ordered back to England to train for the pending Allied invasion of nothern Europe. However, he had contracted infectious hepatitis, for which he was hospitalized, and lost almost 30 pounds. Learning that he was to be evacuated to the United States, he gave his pistol to a fellow patient, a scout who had lost his. Another patient sketched his portrait and presented it to him as a farewell gift. He also purchased an authentic British trench coat. (His wife later showed him the label that said "Made in Brooklyn.")

He was hospitalized at Fort Dix for treatment of chorioretinitis and infectious hepatitis, released, sent for the promised radiology training in Memphis, then assigned to the hospital at Camp Wheeler in Georgia. His military commitment finally nearing its end, he was qualified for a medical discharge from the Army not only because of his leg injury and chorioretinitis, but because he had accumulated the highest number of points for battle services. He opted instead for the quicker, standard discharge to return home to care for his wife, who had just been diagnosed with what could have been a fatal condition.

Several years earlier, Margie Warres had invested the money her husband had won at craps on his way to North Africa. They used the money to help open his radiology practice.

Now retired, Dr. Warres lives with his wife of 56 years at their home in Baltimore City. His ankle is still swollen.

Mary Ann Ayd

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While chasing a typhus epidemic during the war, Col. Thomas B. Turner, M.C., was to fly from Naples, Italy, to Casablanca, Morocco, with very bad weather ahead. An Army general aboard expressed rather sternly the sentiments of all present that the plane should not be allowed to leave the ground. The pilot, a young Army Air Force lieutenant, shook his head in disagreement. The general continued to object, but the lieutenant advised this officer of much higher rank who was in charge on that plane, that he had a date in Casablanca which he did not intend to miss and that the plane was going to take off. Luckily, they arrived without incident.

Marion Friedman, M.D.

From Naples to the Brenner Pass

. . . . . .

Capt. Klaus H. Huebner, M.C.

I joined an infantry battalion in Texas, helped ready it medically for combat, accompanied it to northern Africa for more training, and finally walked along with it as it fought its way from just north of Naples, Italy, to the Brenner Pass in Austria.

For obvious security reasons, combat personnel were not permitted to keep a diary on the front line. At fairly regular intervals, however, I managed to scribble my experiences on the back of campaign maps and hide these in my aid kit. Considering the possibility of being captured, I never mentioned units or individuals or places by name in my notes but filled these in later when rotated to a rear area for a rest. Here I also stuffed my accumulated notes into my barracks bag for safekeeping. In 1947. . . I pieced all my notes together in a manuscript in diary form.

After the war people assumed that just because a doctor served in the armed forces he was more competent than a doctor that did not. This was not so. Those on the front lines learned more military tactics than medicine, since facilities to treat casualties were limited: Constant attention to self-preservation was also essential, since medical officers could not be replaced as quickly as infantry officers. A battalion surgeon learned to remain calm in any situation and show no emotion no matter how severe the casualty; he also learned that by his presence alone he gave moral support needed by all casualties. Living with and observing the same men for two years led to a better understanding of the miseries and emotions experienced by infantry soldiers in combat. Their valor was unpredictable; their resourcefulness often astounding; during lulls in activity their pleasures were intense and often basic, since death in the near future was always a possibility.

Training, Fall 1943. Living with the men daily, treating them, and moving among them in their training did, however, give me a profound knowledge of their character, ability, and mental stability, factors that later were most important in treating them under combat conditions. In less than a month I learned how to distinguish the goldbrick from the sick man without help of x-rays, blood counts, or elaborate laboratory procedures. I learned many other things too, things that were not medical but later most useful, such as a good knowledge of the M-1 rifle, carbine, Browning automatic rifle, bazooka, and 60-mm mortar. I also learned to sleep on a mud floor. Soon I could take a complete bath and shave from a helmet full of cold water. I no longer needed a mirror to shave but could do so by feel. I also learned how to go without a bath for two weeks, to eat standing, and to hike 22 miles in less than twelve hours.

On the front by Castelforte, Italy, April 1944. Our casualties are light but steady. Most occur at night and are suffered by boys on patrol. Daylight casualties are usually due to carelessness. During lulls of sporadic exchange fire, the men come out of their foxholes to take sun baths and reveal their positions. Jerry is very clever. He wastes no shells. He waits until a reasonable number of men show their disconcern and until enough are gathered in groups to make shelling worthwhile. Then he opens up with several airbursts, and casualties result. Most wounds are shrapnel. They are puncture wounds of the back, legs and arms. GIs not quick enough to hit the dirt suffer penetrating abdominal wounds. Mortar wounds are more severe. Mortars are more accurate. Falling close to men, they cause extensive mutilation. It is not unusual for one man to have compound fractures of several extremities at one time as well as numerous penetrating wounds of the abdomen and face. Our system of evacuation is rapid. Our field telephone has direct contact with each company spread over the slopes in front of us. As soon as casualties occur, the company notifies us of their location. Our jeep starts off along the road as far as it dares to go. The litter bearers are met by the company aid man, who leads them to the casualty. A first-aid dressing to stop bleeding has already been applied. The victim is carried down the slope on a litter, loaded into the jeep, and arrives at the aid station. Here I remove the original bandage and inspect the seriousness of the wound. The wound is cleansed of dirt and debris, sulfanilamide powder is applied, and the wound is freshly dressed. Plasma is given immediately to anyone showing the least signs of shock. We have over fifty pints of plasma on hand and are very liberal with its use. The casualty receives more morphine, which we have on hand in syrettes, thus eliminating glass syringes and sterilization. Unless he has an abdominal wound, he receives hot coffee and food. We do not evacuate the casualties until dark, since the road to the medical collecting company is under direct enemy observation. The ambulance drives up to our station nightly to pick up casualties. If a man is critical and needs surgery immediately because of hemorrhage from brain, lung, or abdominal injuries, the ambulance makes the run in broad daylight. Traveling alone on the road and clearly marked, the ambulance never draws intentional enemy fire.

A self-inflicted wound always poses somewhat of a problem. Is it intentional or accidental? Carbine wounds through the web of toes, through the heel, and through hands do occur now and then. I hate to accuse a man of shooting himself in order to be evacuated. I suppose most are accidental, although I can never be too sure. It is not my job to pass judgment, but only to treat. The company commander makes the final decision.

Any civilians who insist on roaming the front lines are in extreme danger. They are a nuisance to us and the Germans, since either side considers them possible spies. Thus if an Italian, caught between the front lines, walks towards German lines, we shoot him; if he walks toward our lines, the Germans fire. No matter what he does, he eventually winds up in some aid station with a bullet wound, and frequently it is a mortal one.

The occasional stubborn civilian rummaging near the front lines usually finds himself a casualty sooner or later. Wandering through fields or over roads, civilians frequently step on mines. I see one small twelve-year-old boy who found an unexploded grenade and decided to take it apart. His right hand is blown off, all his fingers of his left hand are mutilated, and a fragment has also penetrated his

right eye. He is a pitiful and miserable-looking sight. We render first aid and evacuate him that night.

Near the Appian Way, May 19. One shell explodes on the street, and shrapnel bounces off the jeep. Instinctively I leap from the vehicle and jump into what appears to be a shallow ditch. Instead, it is a dry moat eight feet deep. In my plunge downward I scrape both my hands raw on the cement walls, lose my helmet, and sprain my right ankle. One of my men falls on top of me. After coming to our senses, we climb out of the moat. In the darkness we spot a shot-up church and seek refuge in its basement, hanging our Red Cross flag on its door so that our location is readily seen. The basement is filled with Italian civilians crying and praying. There is no light, and I can't see much. Off one corner of the basement is a small room that apparently belonged to the priest. It has no windows. Here we can light a candle and treat casualties. Fortunately, we have none. The boys on the highway must be doing all right. It is 3:00 a.m., and we might be able to sleep three hours until daybreak. Completely exhausted, I lie down on a narrow, red plush sofa with broken springs. After several hours I awaken. My face is swollen and itches. I have been bitten by bedbugs, which are all over the couch, are crawling up the walls and are now in my clothing. I am a remarkable sight as we leave the church at 6:00 a.m. to catch up with our walking troops. My jaw is swollen, my left eye is shut, my hands are bandaged from the scrapes the night before, and my right ankle is sprained. Italy is a hell of a place. When not plagued by the Krauts, we are victims of vermin.

> Back at the farmhouse, we spend a very busy afternoon. We set up our aid station in the wine cellar. Our jeeps bring in casualties every few minutes. Many die on arrival from crushed skulls resulting from grenades thrown at close range. Gunshot wounds are numerous. Abdominal wounds are frequent for the first time, all because of the close range fighting raging ahead of us. We have good rear medical support. Ambulances can travel over the narrow dirt roads, and the wounded do not pile up. We give an abundance of plasma. Many German wounded arrive together with ours. They all wear arm bands identifying the Hermann Goering Division. After bandaging the head wound of one Jerry prisoner and giving him a shot of my whiskey, I try my hand at a little interrogation. I ask him how many men are left in his regiment and receive the answer, "Ein deutscher Soldat veraet nichts"(A German soldier reveals nothing). Since that is what I would have expected any captured American to say, I feel ashamed of ever having pumped him for information. He is a good soldier even though he is an enemy.

In the Vicinity of Cori. By morning of June 2 we still have not contacted the enemy. We continue our chase without resting. We follow small dirt roads well marked by 3rd Division troops, who passed over them before us. One of these signs reads, "Purple Heart Alley—Proceed with Caution." The terrain now consists of fields dotted by small hills. Behind each hill could be retreating Germans. To get to the hills we must always cross an open field first. After noon our lead company makes enemy contact. Mortar, machine-gun, and pistol fire break out suddenly. The battalion rapidly deploys to surround the enemy-held hills. There are no buildings in which to put an aid station, and mortar fragments keep us hugging the ground. The last farmhouse I recall passing was at least a mile to the rear. It's too late to retreat to there now; casualties are occurring all around us. I spot a dense grove of trees to my right and practically crawl to its edge. This looks like a wonderful spot—a small forest in which we are completely hidden from view. The Germans must have just left here, however, since their foxholes littered with parts of their equipment are everywhere. I jump into one of the ready-made holes and order my sergeants to direct the litter bearers to this spot. In several minutes, however, I realize my horrible mistake. Some of our tanks have also chosen this woods as cover, and they are drawing heavy enemy counterfire. German shells burst against the trees, and

fragments ricochet all over the place. While I am closely hugging the edge of my hole during a barrage, a shell fragment passes through my pants leg without as much as scratching me. This woods is a living hell. Every few seconds during treatment of a casualty I am forced to jump back into my hole, and the poor fellow lying wounded is left exposed for additional injury. Both doctor and patient are becoming more nervous after each barrage. I decide to make this patch of woods a litter-bearer station only. My only thought is to get the hell out of here. As the ambulance draws up to collect three litter cases that have accumulated, we rapidly load, also jump into the vehicle, and race over the bumpy meadow a mile to the rear into the farmhouse passed an hour ago.

On 8 July 1944, north of Volterra, Italy, Capt. Klaus H. Huebner, 3rd Battalion surgeon, 349th Infantry, displayed great personal heroism and exemplary devotion to duty in hostile fire while administering aid to the wounded and supervising their evacuation. When the 3rd Battalion suffered heavy casualties during an attack on German positions, Capt. Huebner made his way across open terrain in full view of the enemy while a concentration of artillery and mortar shells burst around him, increasing the toll and imperiling every move. Constantly exposing himself to the murderous fire, with utter disregard for his own safety, he attended the casualties, dressing their wounds and directing their removal. As the advance continued, foot mines were encountered and new casualties were sustained, among them two men whose feet were blown off. This courageous officer, fully aware of the great risk to his life in moving through the minefield, unhesitatingly made his way to the side of the injured soldiers and, stopping the flow of otherwise fatal hemorrhages, saved their lives. By evening Capt. Huebner had worked continuously for fifty-five hours, walking many miles but despite exhaustion, he steadfastly refused to stop for rest, heroically devoting his full attention through the night to the wounded of another battalion, administering aid and laying adequate plans for their evacuation to the rear. By his selfless heroism in the face of murderous German fire, risking his life to give immediate aid to casualties who were falling about him as he worked, Capt. Huebner saved many lives with otherwise would have been lost. His unselfish devotion to the wounded has won the admiration of the entire command. . . .

Joseph B. Crawford
Colonel, 349th Infantry,
Commanding

After dark the fighting slackens off enough for my aid station to move up. The Germans always seem to retreat at night, giving us no chance to rest but only to chase after them. On our way forward we still encounter casualties not yet evacuated from the afternoon's fighting. I stumble upon many a familiar face shot through the head. Most are dead. A few are still barely breathing. Treating those with still a faint flicker of life in them in total darkness is a distressing job. Tagging the dead in the dark, with a blanket thrown over you and the corpse, thus permitting the use of a flashlight, is most time-consuming. By midnight we arrive at a railroadbed and small shot-up station. The building is full of holes; these we patch with shelter halves so that we can light candles. Two rooms of the station are crowded with waiting wounded. We work all

night dressing them. Mortar shells fall all around us at sporadic intervals.

Aid Station at a Farmhouse in Mazzola, July 8. Whenever a variety of weapons are used, the number of casualties passing through our aid station is high and the wounds vary in character. This is the case today. Direct hits with 20-mm shells are no problem because the victim is dead. Most men felled with penetrating head wounds from machine-gun bullets are also dead. Shrapnel from 88s and "Nebelwerfers" or screaming meemies is disabling, but many victims will survive if their wounds are in the extremities. The survival rate of large penetrating wounds of the abdomen depends on the amount of invisible internal hemorrhage and how fast the patient reaches an evacuation hospital, where blood can be given and emergency surgery performed. Today an ambulance will not dare to evacuate anybody until it is dark. Frustrating to me is that we can only put on emergency dressings and give plasma and morphine and decide whom to evacuate first, since we must treat on the run and keep moving. I abhor several types of wounds. One chap has a shrapnel wound that destroys the sinus beneath his right cheek, and half of his eye is hanging loose. This is tough care to bandage in a hurry. Another chap has his lower jaw missing, and you can see his entire bloody gullet and vocal cords; he has no chin to hold a bandage. I see two cases of dirty wounds, the bones splintered just above the ankles and flesh torn away caused by mines. Such wounds lead to eventual amputation because they will never heal, since the blood supply here even in a well person is rather poor. One case shot in his lower back can't move his legs at all. He will probably be a cripple the rest of his life. I shall never know, since once I have seen a casualty with a serious wound, I will never see it again; I do not have the opportunities for follow-up. I am grateful that I do not have any burn cases today.

On the Way to the Arno River. On the afternoon of July 13 we approach Villamagna. We scurry over knolls and through orchards. Villamagna lies on another ridge. We walk up toward the village through an olive grove along a path about three feet wide. The Krauts are waiting for us. As the lead company approaches the town, it is slowed down by rifle, machine-gun and mortar fire. To make matters worse we soon learn that the path into town is also heavily infested with shoe mines. As the first mines detonate, the men jump off the path into the olive groves, and these unfortunately are also mined. We bandage leg stump after leg stump. Shrapnel bounces off the trees. I expect to lose one of my feet at every move. We are still on the path bandaging stumps as darkness falls. Thus far, only three-fourths of the village is in our hands. I must get to it before it gets completely dark, so that I can find an aid station in which to work, since most of the casualties need plasma. Using a large stick, I probe the ground before each step and thus gradually inch my way forward. Reaching Villamagna, I enter the first building I see. It is a small grocery store. The windows are broken, chairs and counters overturned. I hear moans in the darkness. Many untreated casualties are lying on the floor. Most of these are again shoe-mine casualties that have crawled into the building for protection. I worm my way through the debris and with the aid of a flashlight apply pressure dressings and administer morphine. Mortars are pounding the street outside. The Krauts have pulled out, know that we are in the town, and keep harassing us. At 1:00 a.m. on July 14, Villamagna is finally in our hands. I cautiously leave the store and step outside. I locate battalion headquarters a few houses down the street and set up my aid station next door to it. Litter bearers collect casualties from all the buildings and bring them to the station. We work throughout the night, splinting, bandaging, and administering narcotics. Villamagna has been a tough objective to seize, being a strongpoint in the German defenses along "Bloody Ridge."

In the Po Valley, April 22. Here's a picture to remember. It's that of a dead German. His grimaced face is bloated and his head lies in a pile of dust. His leg wound stinks and crawls with flies and maggots. What a degrading sight. No one seems to give a damn. How calloused we have all become! Our men don't even give this guy a second look, but just walk over him. He will only be remembered by his loved ones back home. For many years they probably gave unselfishly and unstintingly their time, effort, love, and money to raise him

I treat many Germans. After dressing them, I inquire if they would like to have anything else to make them more comfortable. The most frequent wish is for a small piece of candy. What trivial wishes at serious times!

from infancy to manhood. Who knows how much more they may have sacrificed to give him a good education? Now he lies dead—one lousy bomb fragment put an end to it all. His parents will probably receive a notice that he died a glorious death. You never die in any other way in telegrams or war reports. They will picture him dying nobly in one way or another, but here their imagination stops, and it's a good thing too; could they see him now they would never sleep again.

Cornuda, April 30. I think of past Memorial Days. What were my thoughts during the ceremony? I don't think that my heart really ever bled for anyone in particular. All I ever thought of was, "It's a damn shame so many died and I hope it doesn't happen again." Did I mourn over the guy who ran straight toward a machine-gun nest tossing grenades until he was finally mowed down? Hell no! No one remembered him. Everyone just prays for his own hide. If our dead heroes once believed that they would ever be remembered individually, then they were really wrong. Now, they just belong to a group of dead, a very impersonal group, a group mentioned once a year when everyone gets a day off so that he can go on a picnic. That's not worth dying for.

I am now determined to come out alive. Like any old soldier, I shall be cautious. Old soldiers still exist because they were cautious. This by no means implies cowardice. Being cautious is being smart. You can also call it adaptation to your environment, where the development of a certain additional sense keeps you out of trouble.

In spite of all this feeling of wanting to survive, I really, in a strange sort of way, have enjoyed danger when I have escaped with an unscathed hide, and look forward to other dangers still to come. Why? I can't explain it. For some peculiar reason I have enjoyed cheating death.

But be that as it may, I have said before I am now determined to come out alive. I'll gamble on anything but my life. I'll keep my head down, keep my damn helmet on, probe carefully for mines along my path, keep digging my holes deep, and look for cover as I run. I'll think about each situation first, then face it as planned. No show-off stuff for me. I'll obey all orders to the letter and do nothing more. My instinct for self-preservation is deep seated. Most of the boys I started with in Texas are long dead and buried. My obedience to the principles of basic training have thus far paid off very well. I am alive and healthy. I've tried to be a good doctor. I haven't demonstrated much of my medical knowledge to date—but that is just the point—you don't have any opportunity to do so in the infantry. During almost two years with my battalion I have learned nothing new and am two years behind in my profession. If I come out of this war alive, I will only have gained composure in the face of disaster. No injury, no matter how grotesque or mutilating, will every startle me. I have seen the entire guts spilled out of an abdomen, heads blown off, half of a face missing, holes in chests big enough to put your fist through, hands ripped off at the wrist, feet imbedded with mud and metal splinters and dangling only on a single tendon, eyes pierced by bullets or grenade fragments, bloody heads with brains oozing out, and corpses flattened by tanks. I have seen the worst and managed to stay calm. Perhaps this is an asset.

Mezzano. I am awakened at dawn on May 3, 1945, by crowing roosters. A heavy blanket of fog hugs the meadow. The sun is not yet visible, but its red glow vividly outlines the highest ridges of the Alps. A messenger comes to us from battalion headquarters. We are not to move but are to await further orders. The battalion radio crackles with static and unintelligible phrases mentioning the word surrender, which holds all listeners spellbound. At 10.00 a.m. we receive an original communication from Regiment. The war was over yesterday, May 2, at 6:00 p.m. to be exact.

. . . . I pray in German because I never learned a prayer in English. The village in which I was born lies just ahead of us over a few Alps in Bavaria. Had I not emigrated to the United States in 1926, I would now probably be a dead German on the Russian front like every one of my relatives of comparable age. Instead, I managed to evade the shells and bullets of my former countrymen. How lucky can you get?

Ed. Note: A retired general practitioner, Dr. Huebner began private practice in 1946 in North East, Maryland, where he still lives. The above account is excerpted from Dr. Huebner's book *Long Walk Through War,* published in 1987 by Texas A & M University Press. *Used with permission.* ■

Lt. Col. Theodore E. Woodward, M.C.

Lt. Woodward's experience with typhus in Jamaica made him a valuable asset to the medical corps. As a result, early in 1942, he was assigned to North Africa with a field laboratory unit under Gen. Mark Clark. Ultimately based in Morocco under U.S. auspices at the Pasteur Institute, he demonstrated new typhus diagnostic techniques to French scientists and American military personnel. Using Morocco as his base, he conducted field work in country after country where the disease was suspected. The ravages of infectious diseases were all too evident. In one small hospital facility outside Casablanca, there were patients with plague, typhus, typhoid, and smallpox all in the same room. Living and dead patients were in the same beds. At that time, there was no effective treatment for any of these diseases, and many succumbed.

About that time, the French authorities were using a potentially dangerous live typhus vaccine that caused the illness in about 10% of those vaccinated. Lt. Woodward and others tested a safer, American type vaccine. And time was of the essence. Not only was the disease prevalent all over North Africa, but also in Italy and the Balkan states, two potential areas for Allied invasion following the submission of the Axis in North Africa. The first experimental vaccine resulted in low levels of antibodies in the volunteers. Stronger doses ultimately produced higher antibody levels that provided full protection against the disease. After studies in guinea pigs and monkeys, a key study was conducted in humans which showed effective protection. Lt. Woodward was later made a member of the United States of America Typhus Commis-

"Two American Ambassadors, five army officers, and three navy officers were recently awarded the United States of America Typhus Commission Medal in recognition of their 'exceptionally meritorious service' in the control of typhus. The recipients of the awards and the citations accompanying them include:

"Major Theodore E. Woodward, formerly of Westminster, Md., 'for exceptionally meritorious service in connection with the work of the United States of America Typhus Commission. At Casablanca, Morocco, Major Woodward, arriving with the invasion forces in 1942, instituted at once cooperative studies with French scientists at the Pasteur Institute with a view to control of the epidemic of typhus at this port and in this region. As a result, protection for American troops was enhanced. Later, as a member of the United States of America Typhus Commission, Major Woodward participated actively in the combat of typhus at Naples and in the Aden Protectorate. Finally, in a position of high responsibility he has been a representative of the commission in the European theater of operations, rendering service to military and civilian agencies before and during the invasion of Europe. Major Woodward's activities, covering a wide range of original scientific work and administration responsibilities, have been carried out with intelligence, energy, tact and devotion to the cause of protection of the military forces against typhus.'"

JAMA 1945;12:401-402.

"Immediately after the establishment of the Field Headquarters of the U.S.A. Typhus Commission in London in May 1944, it became engaged in training personnel of the British, the Free French, and the Netherlands Government-in-exile in the latest methods of typhus control, including lessons learned at Naples. This instruction was directed by Major Woodward whose diagram of the positions of dusting DDT powder with a hand duster became a one-page manual used from Europe to the Far East."

From: Coates JB Jr, Hoff EC, Hoff PM, eds. *Medical Department, United States Army. Preventive Medicine in World War II. Communicable Diseases. Arthropodborne Diseases Other Than Malaria.* Vol. VII. Washington, DC: Office of the Surgeon General, Department of the Army; 1964:238.

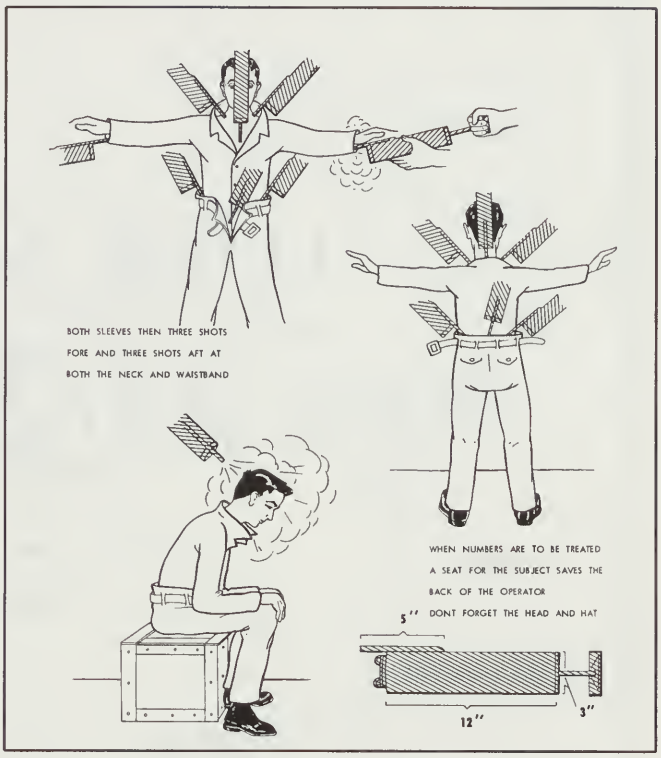


Diagram drawn by Maj. Theodore E. Woodward, M.C., when he was training typhus control personnel in London in 1944, applying information gained in North Africa.

Reproduced from: Coates JB Jr, Hoff EC, Hoff PM, eds. *Medical Department, United States Army. Preventive Medicine in World War II. Communicable Diseases. Arthropodborne Diseases Other Than Malaria.* Vol. VII. Washington, DC: Office of the Surgeon General, Department of the Army; 1964:218.

sion, which was appointed by executive order of President Franklin D. Roosevelt.

While in North Africa, Lt. Woodward also contracted a mild case that nevertheless produced a fever of nine days' duration and severe headaches.

Late in 1943, after the Allies had liberated southern Italy, Naples was in the midst of a violent epidemic of typhus. Thousands of refugees each day came into the city after the German army left. As many as three families lived in a single room, sanitation was almost nonexistent, and lice were breeding rapidly. Because Naples had been typhus-free for three decades, the population lacked any immunity. They became infected in droves, and many died. Yet not one American soldier died of typhus thanks to previous inoculations against the disease. DDT, which had just become available, was used to stop the epidemic in the area, since it rapidly killed lice. People voluntarily lined up for dusting with the powder. Later, in southern Yemen, then-Maj. Woodward and his associate persuaded the Emir and his bodyguards to be dusted publicly in the marketplace for all to see. He also gave instructions to those in charge of typhus control programs in England, Normandy, and other areas in northern France.

MARION FRIEDMAN, M.D.

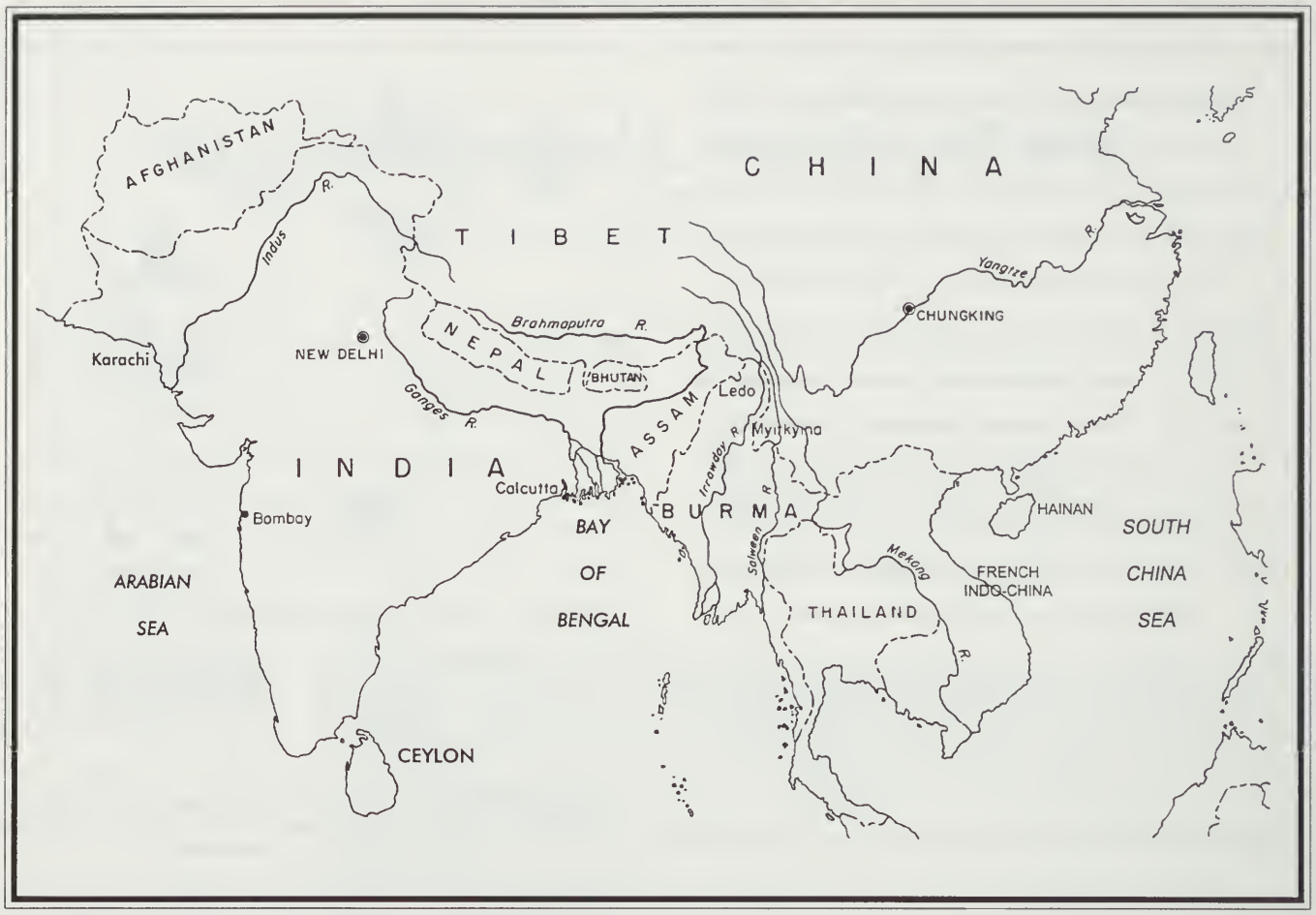
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Woodward TE. Personal interview, August 1995. ■


AFGHANISTAN
Indus R.
C H I N A
T I B E T
Yangtze R.
CHUNGKING
Brahmaputra R.
N E P A L
BHUTAN
NEW DELHI
Karachi
Ganges R.
ASSAM
Ledo
Irrawaddy R.
Myitkyina
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Calcutta
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OF
BENGAL
Salween R.
Mekong R.
FRENCH
INDO-CHINA
THAILAND
ARABIAN
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CEYLON

In Burma with Merrill's Marauders

. . . . . .

Capt. James E.T. Hopkins, M.C.

In September 1943, I joined a group of 650 men and officers in New Caledonia who had volunteered for an infantry battalion being formed for a special mission, the location and nature of which we did not know. We were later joined there by 250 more men and officers. Most of us had been overseas for more than a year and had seen action in the south or southwest Pacific areas.

These men made up the 3rd Battalion of what was to become the 5307th Composite Unit (Provisional), later known as Merrill's Marauders. We traveled to India on a transport with a battalion from the United States that was to become the unit's 1st Battalion, and a battalion from the Caribbean area that was to become its 2nd Battalion. From Bombay, we entrained for Deolali, a location that for more than 100 years had been a major British military camp. There, we learned that we had been, and would remain, under British control for a campaign in Burma at an unspecified time and location. Our training would be under the supervision of British General Orde C. Wingate, who in the spring of 1943, had commanded 3,000 Indian, Burmese, Gurka, and British troops in a long-range penetration of Burma. They had used mules and horses and been supplied by parachute drops. After harassing the Japanese for three months, they had withdrawn. In mid-November, after three weeks at Deolali during which we received almost no additional information or training, we entrained for another British camp at Deogarth, 700 miles away.

Until early January 1944, we were scheduled to fight in north central Burma under the command of Gen. Wingate. The British made no effort to teach us anything about the proposed operation. Most of the Americans did not know that President Roosevelt and General Marshall had decided to organize and supply our infantry regiment and then turn it over to the British in India for the attempted reconquest of Burma. We did not know of the great build-up of American personnel in Asia. We learned after our campaign was over in August 1944, that as of January, the strength of the U.S. Army Forces in the China Burma India (CBI) Theater of Operations totaled 105,073. While in India, our

units had absolutely no contact with any of these American military personnel.

Medical personnel were very busy at Deogarth. As the Orange Combat Team surgeon for the 3rd Battalion, I spent about half my time in the medical tent. Sick call was on a fairly continuous basis. Malaria was a significant problem; more than half the men in my unit had been infected during the past year. For reasons unknown to me, the policy set up during our voyage from New Caledonia, to withhold prophylactic Atabrine, was continued until the situation became intolerable in my unit. During the first five weeks at Deogarth, we treated between 200 and 300 cases of recurrent malaria. Although the prophylactic use of Atabrine was not widespread in the CBI area at that time, some of the Pacific veterans ignored the order to withhold Atabrine and continued its use with good effect.

During training, the men of Unit C became so adept at raiding the other battalions' kitchens that we were nicknamed the "Chow Raiders." Proud and flattered, we soon found a use for the small collapsible can opener supplied with 10-in-1 field rations. For the group with no logical name, no flag, no colors, no history, no chaplain, no dentist, no recreational facilities, no post exchange, no leave, inadequate transportation and facilities for personal hygiene, poor general health, and many months without female companionship, the can opener became a prized insignia. We wore it with pride, pinned to the lapel of our fatigue jackets.

All medical officers were aware of the need to keep the men on active duty. No effort was made to do careful and complete physical examinations to eliminate those unable to meet Army standards. Those of us who had been in combat knew that the military situation frequently required that good medical practice and humane action had to be ignored in order to keep infantrymen at the front. We had seen no evidence of replacements in the Pacific battles and our small isolated unit had no promise of any in Asia. We were the only infantrymen in a vast area at the extreme end of the supply line. We depended on the regimental surgeon for liaison with higher authority. During our period in Asia, before and during combat, no representative of the Surgeon General or the Theater Surgeon ever visited us. Anyone who has given any thought to jungle warfare or actually taken part in it, however, would know that superb physical condition of the officers as well as the men is essential.

In January 1944, orders were issued that changed the three American battalions from a composite regiment to the 5307th Composite Unit (Provisional) under the command of American Brig. Gen. Frank D. Merrill. Still no attempt was made to educate the men about the military situation in the CBI area. Nevertheless, the change in plans raised our spirits.

At the end of December 1943, 360 large, healthy, very active mules arrived at camp from New Orleans. Despite the long ocean voyage and train trip from Calcutta, they were in wonderful condition. We also received 100

The units on the ground coordinated supply drops with the Second Troop Carrier Squadron. Records showing what each battalion had on hand allowed approximate prediction of its needs on a certain date at a certain location. Parachute packers could assemble every kind of load the ground units could ask for. Twenty-four hours in advance, a drop area was chosen, which was always in enemy territory. Kickers aboard the unarmed C-47s arranged the loads (totaling about 7,000 pounds) so they could shove them from the transports at the proper time and location without damaging the plane or killing themselves. Air-to-ground communication was maintained to avoid mistakes. The unit on the ground marked the drop area, which was defended by a combat team, and the sky was searched for enemy aircraft. The pilot came into the wind at near stalling speed at an altitude of 400 feet or less, judged the exact time for the kick, signaled the kicker, and dropped the plane's nose to give extra clearance at the tail. Free drops were made for animal food, clothing, and plastic bags of water and gasoline. Other supplies, including ammunition, were attached to parachutes. Work details rushed onto the field, cut the chutes, and carried them into the jungle for concealment. Others moved in with animals to haul the loads to a more protected area. Everyone on the ground had to be careful to avoid being injured or killed by an object delivered without a parachute.

emaciated, unconditioned horses that had been used first in New Caledonia and then in India. Although the animals created great excitement, most of the infantrymen had never been close to a mule or horse. They soon learned that one of every four men would be leading one. We developed great admiration and respect for the men of the pack train units, who were not only exceptional mule skinners, but great teachers. The men who had been assigned to an animal learned to lead their charges to water, measure oats, tie and untie their animals at the picket line, pack and unpack loads of equipment, and use curry combs and brushes. They also learned that a mule's back legs pack a powerful wallop that could be (and in some cases was) lethal.

Shortly before our departure for Burma, the battalion surgeons learned that our chief source of food would be K rations, supplemented when possible by C or 10-in-1 rations. K rations contained 3,000 calories and were to be consumed only under emergency conditions when no other food was available. Breakfast was 4 graham crackers, 4 hard biscuits, a 2-ounce can of egg-meat mixture, several dextrose tablets, a packet of soluble coffee, 3 sugar lumps, a stick of chewing gum, and 4 cigarettes. Lunch was 2 ounces of cheese, a fig bar, lemonade powder, and several crackers. Supper was 2 ounces of canned meat, soluble bouillon powder, and a 2-ounce chocolate bar, biscuits, a stick of gum, and 4 cigarettes.

At the request of the 3rd Battalion, Gen. Merrill arranged for the men to have a small canvas container to attach to the rifle belt. Each man was to procure, keep available, and use Atabrine for malaria prevention and Halazone for water purification. He could also store vitamins when they were available. All carried standard wound dressings and sulfadiazine tablets. Several snakebite kits were supplied to each squad.

During the third week in January, the regiment began the 125-mile march up the Ledo Road from Assam over the mountains into Burma. The 3rd Battalion started the march into Burma at 1800 on February 9, 1944. The Orange Combat Team Medical Detachment consisted of one or two doctors, two or three aidmen, and two packhorses. At first we marched at night, a tactic abandoned when Tokyo Rose soon announced that an American division was advancing into Burma. The campaign would take the 5307th Composite Unit (Provisional) on foot between 700 and 1,000 miles over the mountainous and jungle terrain of northern Burma.

Many thoughts went through my mind. At no time had we been given any significant briefing. Few if any of the men or officers had any knowledge of the political ramifications of the relationships among England, India, China, and the United States. We were never told why we were asked to volunteer. No one explained why we were abandoned by the U.S. Army forces in the CBI theater, first in an inadequate transient camp in India for three unproductive weeks, then in an isolated British camp with inadequate sanitary facilities, religious support, food, and organization.

No effort was ever made to explain why we were suddenly returned to the U.S. Army. We had no significant headquarters until three weeks before combat. Significant hospital help was at a great distance with slow and questionable transportation. There were no arrangements for essential personal hygiene. We had no insect repellant. Few, if any, representatives of any branch of the U.S. Army visited the unit. A well-trained, highly qualified senior member of the unit was bypassed and Gen. Merrill was appointed commanding officer. His first visit to the unit occurred three weeks before we moved toward Burma for combat. Gen. Merrill was qualified from a military standpoint, but no one told us he had had a heart attack in 1942.

Marching toward the enemy, the men had no previous conception of the terrain or the history or condition of the road ahead. Those of us who had been in the Pacific won-



View of the Ledo Road.

Reprinted from: Hopkins JET. Casualty Survey—New Georgia and Burma Campaigns. In Coates JB Jr, Beyer JC, eds. *Medical Department, United States Army. Wound Ballistics.* Washington, DC: Office of the Surgeon General, Department of the Army; 1962:245.

dered why the battalions were not supplied with pack artillery. It was inconceivable that an infantry unit should be asked to enter combat without it, especially when the enemy was a master of its use.

The air supply system was to fill our needs for plasma, intravenous fluids, dressings, and medications. Penicillin was not available to our unit, and we would depend on sulfadiazine to treat and prevent wound infection. We had no satisfactory treatment for amoebic dysentery. We would have to depend on the Halazone tablets in our canteens to purify our water.

Lagan Ga was about 16 miles away and the march would take us across two rivers and numerous small streams. The battalion commander kept us moving despite the total darkness. In six hours the column moved about eight miles. I remember falling asleep during several 15-minute rest periods. Decaying vegetable matter from the jungle floor, which tended to glow in the dark, was placed on the animal or man in front as a sort of guide light.

Our men knew they were facing death, injury, and illness. Word had leaked out that the War Department expected about 80% casualties. No replacements were planned for men lost due to battle deaths, wounds, and sickness. I could not help but wonder what would happen when our ranks became so limited that we would no longer be an effective fighting unit. Despite the great effort of the medical officers, some men left for combat in poor physical condition, especially those subject to recurrences of malaria. As time ran out, I had become increasingly shocked that no plan for evacuation of the sick and wounded had been worked out by the combat group. The idea that we were expendable seemed to be a logical conclusion. Nevertheless, the general attitude of the men was, let's get the job done.

The three battalions operated along separate trails for the greater part of the Burma campaign. On February 25, our first engagement with the Japanese occurred. It was the first American infantry action against the Japanese on the Asiatic continent during World War II and the first since the Boxer Rebellion in China in 1900. By the second week of March, the 1st Battalion, reinforced by a Chinese regiment, had marched across the Aipawn Bum Mountains to engage the Japanese at Shaduzup in the Mogaung Valley. Meanwhile, the 2nd and 3rd battalions crossed the Wangabum Mountains. It took 25 days for the battalions to walk the 150 miles to the area beyond which contact with the enemy could be expected. For all but 10 days we ate only field combat rations.

During the Battle of Walawbum, more than 100 men of the 2nd Battalion were killed and many more were injured. One private who sustained a serious abdominal wound would not survive without immediate surgery. Because of the impossibility of rapid evacuation, my good friends from Baltimore, Capt. A. Lewis Kolodny and Maj. Bernard Rogoff, placed him on a litter resting on two ammunition cases. Under the most primitive conditions, and despite heavy firing, they sewed up the holes in his perforated, protruding intestine and closed the wound. He made a good recovery.

From the very beginning of the 5307th, the combat surgeons had been pressing the regimental surgeon for some plan of evacuation for the sick and wounded. The generals seemed to have no answer to this problem. The medical officers were not told that a plentiful supply of American L-4 and L-5 planes with pilots were in the CBI theater. We did not know these planes could land on rough, short runways and sandbars. No one explained that they could be used as ambulances. By March 4, despite Japanese ground activity and intermittent shelling of Lagan Ga near Walawbum, an area was almost cleared for an airstrip to be used by liaison planes. Casualties were beginning to collect at Lagan Ga, and something had to be done. With the help of the enthusiastic pilots, wounded men finally had a means of evacuation out of Burma. It was a big boost to morale.

The 2nd and 3rd battalions engaged the Japanese at Inkangatawng. The success of the operation enabled Chinese troops to advance rapidly down the Mogaung Road, but they failed to fulfill their assigned mission and our two battalions were forced to withdraw to the mountains. There, the 2nd battalion was cut off. Although we had faced the enemy quite frequently in the South Pacific, we were always part of a larger unit.

When all the men and animals had to get off a trail because of enemy planes, we really heard cursing from the mule skinners. No mule likes to be dragged off the trail where he can't see the other mules. And when a mule with 300 pounds on his back says no, it's tough to change his mind. Taking the mules off the trail in pairs finally solved the problem.

We dug in as soon as we reached the knoll. A burst of machine gun fire split the silence and hit a scout. I crawled out and pulled him back to the perimeter. From our slit trenches, we could see the tan uniforms of the Japanese coming toward us. We opened fire. They hit the ground and fanned out, crawling closer and shooting ferociously. Seconds later, their mortars started coming at us in salvos. The main attack was coming in the center of my platoon's defense. The sergeant relayed a radio message from the main body of the Marauders that they had driven the enemy from the opposite bank of the river and had reached their position near Walawbum. They could help us with their mortars! We radioed back our estimate of the Japanese positions and soon the crack of a mortar discharged across the river, but too far to one side. "Anybody got a compass with mills on it instead of degrees?" I shouted. An aidman, who had just finished pouring sulfanilamide powder into the scout's stomach wounds, opened a pouch at his belt, handed me a compass, and grinned, "We medics have got everything." I calculated new figures, got them radioed to the mortar crew across the river, and soon the mortars were right on target. Still, the Japanese kept coming, edging around all three sides of our perimeter, trying to get between us and the river. I estimated there were at least 200 troops opposing us. Suddenly, we got orders on the walkie-talkie to join the battalion on the other side of the river. Some of the men buttoned fatigue jackets over bamboo poles to create makeshift litters for our wounded. Under cover of mortar fire, we withdrew to the river bank. On the other side, gunners and riflemen opened fire to cover our crossing. Bullets whined over our heads. Japanese were on our flanks, ready to knock us off as we crossed. Two men peeled off their white undershirts and put them on a tree on each flank of our platoon to serve as firing guides. I ordered mortars to throw smoke shells to the rear and both flanks to screen our move. One by one, we splashed back across the river.

Now, in the process of accomplishing our mission, we had been surrounded. With the aid of air-dropped pack artillery, the 3rd Battalion engaged the Japanese for nine days in a major battle to free them.

In the 3rd Battalion on March 5, Lt. Armstrong and I stayed at our position with the Medical Detachment near the center of the perimeter. We were constantly ready with blood plasma and dressings to care for the wounded. By some miracle there were no dead or wounded among the men of Orange Combat Team on this day. In the medical station we spent our time digging our foxholes deeper. When I was not busy, there were brief periods of doom in my thoughts, but they did not last. I had been in worse situations on New Georgia. The men in Orange had my total confidence. I knew we would come through. The chief problem was not knowing what was going on a few yards ahead. When darkness came we had been 48 hours without food. We had brought one mule into the aid station to unload some supplies and lost him to shell fragments. Despite our hunger, we were too busy and under too much tension to consider butchering him for a quick meal.

In late February 1944, the British foreign secretary, Anthony Eden, told the House of Commons, "If any of us had the choice we would say that of all the ordeals the military could be put in, warfare such as the troops are now engaged in on the Burma frontier is perhaps the toughest of all." On hearing of this statement far behind enemy lines, one of the Marauders, a veteran of Guadalcanal, said, "What does he mean by 'perhaps?'"

After the Japanese had been routed at Shadazup and Inkangatawng, in the third week of April, the three battalions assembled at the base of the Jaupadu Bum Mountains for the Myitkyina campaign. For this campaign, the 1st and 3rd battalion, each with a Chinese infantry regiment, were used. The 2nd Battalion was held in reserve. Two major battles in the Myitkyina Valley ended in complete success for the U.S. forces. The 1st Battalion captured the Myitkyina airfield on May 17, and shortly thereafter some 4,000 engineer and infantry troops were flown in. For most of the men of the original 5307th, the campaign lasted another three weeks. The town itself did not fall for another 2½ months, when it was taken by Chinese forces and remnants of the 5307th. ■

Capt. James E.T. Hopkins, M.C.

A 1941 graduate of The Johns Hopkins University School of Medicine, James E.T. Hopkins completed one year of training, then volunteered for military duty in April 1942. He was attached as a first lieutenant with Hopkins' 18th General Hospital and served with that unit for 10 months on Fiji, treating wounded men evacuated from the battle raging on Guadalcanal. While there, he became profoundly interested in the welfare of the infantry soldier—an interest that would spur him to collect all possible data on combat casualties and later to recommend the use of body armor to protect the vital areas of the body during combat.

In March 1943, his commanding officer on Fiji, Col. George Finney, explained that the 117th Combat Engineers, who were soon to depart for Guadalcanal, needed a volunteer to join them as their combat surgeon. Lt. Hopkins wanted to go and considered himself lucky when he drew the short straw. After a few days on Guadalcanal, he was transferred to the 1st Battalion of the 148th Infantry Regiment of the 37th Division, with which he was soon shipped to New Georgia. His regiment landed on Rendova Island on July 18. The medical detachment had to be an intimate part of the battalion at all times. Casualties began immediately and continued daily. At one point, his unit was surrounded by the enemy for four days without food. Because of his close proximity to the battles, Lt. Hopkins began to keep careful records on all the wounded.

Following the battle in the Solomons, he volunteered for the unknown, but "dangerous and hazardous" mission that would take him into Burma with Merrell's Marauders.

The trek into Burma that began in February 1944, across rivers, through dense jungle, and over the foothills of the Himalayas, was undertaken with maps made by the British in 1915. "Villages" on the maps often turned out to be a few huts. The radios the men carried were large and cumbersome, and transmission was often cut off by the mountains. By mid-April, their strength had been halved.

The men suffered from amoebic dysentery because they often could not light fires in enemy territory to boil water. The low caloric content of their K rations resulted in weight losses that ranged from 30 to 100 pounds. About 130 men contracted tsutsugamushi fever; 40 died. The nights were cold and it rained often, sometimes three or four times in one day. The men developed jungle sores from marching in wet boots. Leeches got in their ears, on their lips, in their mouths, and in other "unmentionable" places. Surgery was often performed with the physician bending over the soldier on the ground. At other times, the wounded man was put on a litter elevated on bamboo stilts to save the surgeon's back. They had abundant morphine, but no good way to sterilize surgical instruments. The physicians improvised by putting their instruments in bamboo buckets containing a solution of zephiran powder and water. The first casualty evacuations often involved strapping the wounded to the wings of Piper Cubs. Many of the animals died, and their decaying carcasses attracted bluebottle flies by the billion. If a mule skinner was sick, injured, or killed, another man had to learn on the march how to lead, feed, and care for a mule. Once, while Lt. Hopkins was returning to his bivouac from a 5-mile ride to visit a sick native, his horse collapsed beneath him, dead.

As he had on New Georgia, Lt. Hopkins kept detailed records of all the dead and wounded in the 1st and 3rd battalions of the 5307th Composite Unit (Provisional) in Burma. Back in the United States in the fall of 1944, he began work on his comprehensive wound ballistics study that would later be published as part of the official report on World War II by the Office of the Surgeon General of the Army. In addition to his own records, he used the men's emergency medical tags and other records at Walter Reed Army Hospital to help compile the report. The bulk of the information, however, was obtained firsthand. He wrote, "In this type of warfare, officers and men lived in close association with each other. [I] secured much information on the battlefield, where [I] often acted as an aidman, and from close association with company commanders during actual fighting and with others in a position to know the facts." Among the data Lt. Hopkins recorded were:

- name of the casualty, with his rank, serial number, and unit;
- type of action; type of terrain with available cover; and duty of the casualty;

- weather conditions and time of day;
- anatomic location of the wound and degree of severity;
- type of causative agent and approximate range;
- treatment received;
- classification of the casualty as to type and eventual disposition;
- classification as to the possible avoidability of the injury.

His records were so precise Dr. Hopkins was able to tell one family what had happened to their loved one 50 years later.

After the war, Dr. Hopkins returned to Johns Hopkins Hospital, where he was an assistant resident in surgery. He later trained in thoracic surgery. Now retired from medical practice, he lives in Baltimore, where he is writing a book detailing his experiences in the Pacific and Burma.

Mary Ann Ayd

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THERE was no dermatology consultant in the China-Burma-India theater during the war. The three general hospitals assigned to India had dermatology sections. The 20th General Hospital, which arrived in March 1943, was located in Assam, near the border of Burma. The 69th General Hospital, also assigned to Assam, arrived in June 1944, during the height of the intensive campaign being conducted by Merrill's Marauders at Myitkyina. The 142nd General Hospital arrived in Calcutta in September 1944. Each of these hospitals had from three to five wards set aside for dermatology and syphilology,

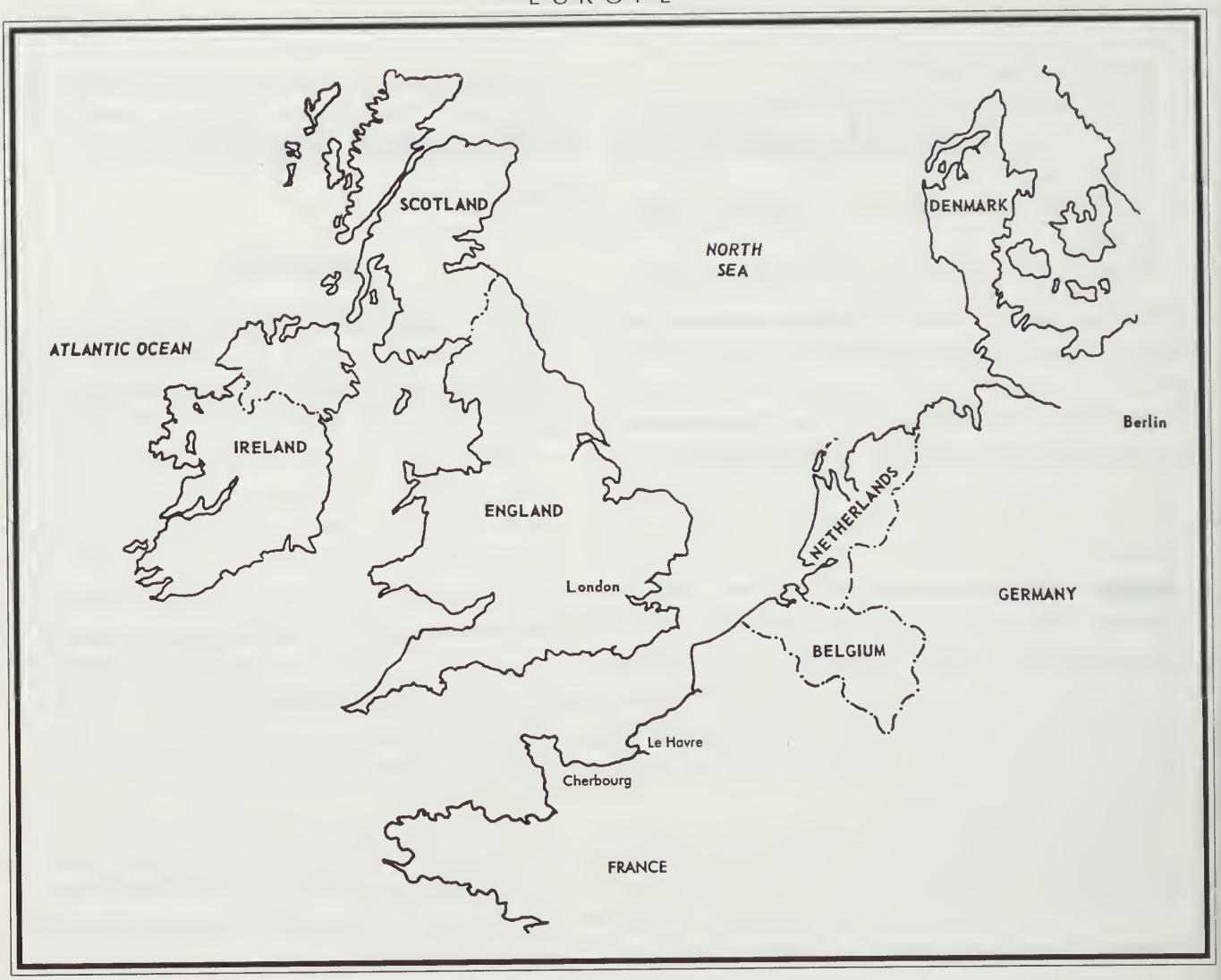
The venereal disease rate in India among U.S. troops was one of the highest encountered in any theater or area in World War II. Although syphilis and gonorrhea were the major problems, chancroid and lymphogranuloma venereum were common. It was not unusual for a man to report for treatment with two, three, or even four separate venereal diseases at the same time, following several exposures over a short period.

Dermatologists of the 20th, 69th, and 142nd General Hospitals played an important part in the management of these patients. During 1944 and early 1945, one of three wards in each of these hospitals was continuously filled with men with early syphilis, chancroid, lymphogranuloma venereum, or combinations of these diseases. Penicillin became available in the theater for the treatment of syphilis in September 1944, but supplies were limited.

The major dermatologic problems in Burma and India were quite similar to those encountered in the Southwest Pacific Area. Many skin diseases with a high incidence in the United States were also common in the China-Burma-India theater. During the hot, humid monsoon season in particular, primary bacterial infections were widely prevalent, especially ecthyma and bullous impetigo. Secondary bacterial infections of eczematous eruptions, contact dermatitis, and tinea pedis were common, and their course was protracted. During the summer months, the incidence of miliaria rose to 75 percent in some units, and the condition was often incapacitating.

A unique form of contact dermatitis observed in the China-Burma-India theater was dhobie mark dermatitis. Other cutaneous diseases of interest and importance in U.S. personnel included cutaneous diphtheria and the lichenoid and eczematoid dermatitis syndrome caused by Atabrine. Among the unusual cutaneous diseases and systemic diseases with cutaneous manifestations seen in Chinese troops were leprosy, kala-azar, tuberculosis, syphilis of the bones and other deeper structures, and true tropical phagedenic ulcer associated with malnutrition. Superficial fungal infections were identical with those that occur in the United States, but they were more frequent, more extensive, and more difficult to control.

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SCOTLAND
NORTH SEA
DENMARK
ATLANTIC OCEAN
Berlin
IRELAND
NETHERLANDS
ENGLAND
London
GERMANY
BELGIUM
Le Havre
Cherbourg
FRANCE

JUNE 6, 1944

Brig. Gen. Edmund G. Beacham, M.C.

. . . . . .

"The Bronze Star Medal was recently awarded to Major Edmund G. Beacham, formerly of Baltimore, for 'meritorious achievement in military operations against the enemy from June 7 to July 4, 1944, in Normandy, France.' Dr. Beacham graduated from the University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore, in 1940 and entered the service February 3, 1941."

JAMA 1945;127:163.

IN THE SPRING OF 1944, U.S. military personnel and equipment were pouring into England at such a rate that a popular comment was that the island was held up only by the numerous barrage balloons anchored along its shores and around its cities. The 29th Infantry Division (men originally from National Guard Units of Maryland and Virginia at the February 1941 induction) was now filled with men from all over the United States. The division landed in Scotland in the fall of 1942, went by train to Tidworth Barracks on Salisbury Plain for further training, then gradually moved south to its final English destination, stretched from Plymouth to Land's End at the southernmost tip of Cornwall. There, the division went through many retraining cycles, maneuvers on the moors, and amphibious landing exercises against defended beaches on both coasts of England.

Most of the physicians in the 29th Infantry Division on D-Day, June 6, 1944, had graduated medical school within five years. There were a few senior physicians in field grade levels in the medical battalion. All sections of the United States were represented.

All physicians went through Medical Field Service School for basic training in military medicine, tactics, and etiquette. Most had been on multiple training exercises with troops before invasion. Some had participated in England in courses at the London School of Tropical Medicine or in courses of instruction in management of psychiatric illness.

With increasing numbers of U.S. military personnel in England, medical units and facilities were added to keep pace with medical needs. Each infantry battalion (about 1,000 men) had attached physicians and medical aid men. Larger

units such as regiments (about 3,600 men) also had dentists and other medical technicians. Divisions (20,000+ men) had a medical battalion with about 30 physicians and the ability to care for most minor illness and injury. In addition, U.S. medical dispensaries, station hospitals, and eventually military general hospitals were placed throughout England to offer backup medical care for more complex problems. Local English hospitals occasionally took care of emergency injuries and disease, but in general, U.S. troops were well covered medically by their own team.

As the 29th Infantry Division prepared for embarkation, units were moved into oval isolation areas called "sausages" (from their outlines on maps) where they received orientation for their invasion task. Initial invasion plans called for heavy bombardment of enemy beaches and surrounding areas, air cover, paratroop drops in some places, and eventually infantry assault landings on selected beaches. Normandy and the beach line designated "Omaha" were the D-Day targets for the 29th. This National Guard unit, along with the Regular Army's 1st Infantry Division, was selected to make the primary American assault. Other American units, as well as British and Canadian troops, would land on other beaches.

Invasion

The 29th division was loaded onto ships June 4 and 5, 1944, to cross the English Channel. During the early morning of June 6, men of the 116th Infantry Regiment (Virginia National Guard) transferred to smaller boats holding about 30 men each and started toward the shore. Riflemen and men armed with flamethrowers and demolitions including Bangalore torpedoes made up the early boatloads. In carefully planned increments, heavier weapons, machine guns, mortars, then jeeps (quarter-ton trucks), tanks, and artillery pieces would make their way ashore. Medical personnel would come in interspersed with later waves of infantry. However, among early arrivals on the beaches were engineer and other medical units to help care for wounded personnel.

According to the Geneva Convention, medical personnel (enlisted and officers) were unarmed and wore Red Cross arm bands (some aid men wore these on helmets for better visibility). Ambulances and medical jeeps were marked with the Red Cross symbol, as were medical tents (not within close vicinity to proper military targets). Since physicians were unarmed, they theoretically needed no further protection than the Convention. In almost all instances, on both sides, this was respected in the European Theater of Operations.

Because of heavy seas, few 29th divisional units landed at their appointed places. With the tremendous Allied air superiority and incessant naval bombardment, however, time allowed enough men to land and enough reorganization that the bridgehead was expanded and held.

Most medical care on the beaches was first aid by the wounded themselves with their own dressings and sulfonamide tablets kept in the first aid pouches, by morphine injected by medical aid men when available, and by grouping of wounded at collecting points. Medical evacuation was initially by boats that had dropped off their load. This was difficult because the boats had to approach and depart quickly during the early hours when defensive fire was heavy.

Major clinical conditions in the invasion resulted from shell fragment, bullet, and blast wounds. Head wounds, abdominal wounds, fractures, bleeding, shock, and psychiatric casualties were frequent. Most were rapidly evacuated to the rear, many to England early in the invasion period.

Troops were brought in on LCVP (Landing Craft Vehicle/Personnel). The front of the ship opened like a hinge when the ship reached the beach. Sol-

KILLED IN ACTION

"Bernard Joseph Sabatino, Baltimore: University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore, 1938; served an internship and residency at St. Joseph's Hospital; began active duty as a first lieutenant in the medical corps, Army of the United States (National Guard), February 3, 1941; later promoted to captain; field hospital surgeon with the twenty-ninth division; killed in action in the European area, June 6, 1944; aged 31."

JAMA 1945;127:180.

diers then went into the water and presumably waded to the beach. These boats opened their doors at various levels of water, and some personnel landed in deeper water than others. Movement was rapid, since boats and landing soldiers were under fire.

Among the early medical units of the 29th Division to land were the medical detachment of the 116th Infantry Regiment and part of its attached B Company of the 104th Medical Battalion. Capt. Lester N. Kolman, M.C., of Baltimore, company commander, went forward as planned, outstripped his own troops, was captured, and spent 58 days as an enemy prisoner. He eventually was returned to complete the war with the division. Col. Dwight H. Mohr, M.C., of Baltimore, led the 104th medical regiment. Capt. Bernard J. Sabatino, M.C., with the 111th Field Artillery Battalion, was killed coming ashore with his unit.

Once the 29th Division began to move inland, early evacuation was by litter bearer, then jeeps, and finally by three-quarter-ton ambulances as they were able to make their way forward. Because of the stiff defense, the landing schedule was delayed so that units expecting to be landed in the first few hours were backed up until later in the day. The 115th Infantry Regiment (originally from Maryland counties) came in after 10 a.m. on June 6, and the 175th Infantry Regiment (Baltimore City) remained offshore until it came ashore early on June 7 as Corps Reserve.

Invasion troops wore specially impregnated clothing and carried gas masks because of the possibility of chemical warfare. Many masks were discarded early, but the stiff, stinking,

Edmund G. Beacham was talked into joining the "Dandy 5th" (regiment of the National Guard) by his roommate, which he did in August 1939. An enlisted man during medical school, Dr. Beacham became an officer following his graduation in 1940. In February 1941, he was called to active duty and sent to Camp Drum in New York, where the men trained with pipes that stood in for guns and trucks that stood in for tanks.

At Fort Meade in the spring of 1941, his unit went to full strength with draftees; the medical officers trained with the infantry as a unit, then went to various parts of the country for field training with larger and larger units. By the fall of 1942, the 29th Division was spread throughout southern England, and training began in earnest. Beach landings and troop movements were practiced continuosly, and many of the physicians also studied at Oxford and the School of Tropical Medicine and Hygiene in London.

Maj. Beacham's company included 125 enlisted men, 8 physicians, and 2 dentists. On D-Day, they had to scramble down rope nets into small boats to go ashore. The water was rugged, and most of the men were seasick. Although they had been reasonably well briefed, as the battle moved off the beaches and into the French countryside it became apparent that at least one aspect of the terrain had been overlooked: the hedgerows. The march to St. Lô took six weeks, rather than the predicted one.

Shell fragments from artillery were the cause of most wounds ("the German 88 mm guns were rough"). Actual medical treatment in the field, however, consisted of little more than first aid: applying a splint to a broken leg, a tourniquet for hemorrhaging. The wounded were stabilized as much as possible and then moved to the rear. Although penicillin was available in the hospitals, it was in short supply and was not used in the field until the war was nearly over. Instead, the physicians relied on sulfa drugs.

During the early weeks of the fighting, few troop replacements were available, and the men often succumbed to combat exhaustion. In September, Maj. Beacham, as the division surgeon, was asked to work on the problem. He devised a system to move soldiers to the rear for a bit of rest and relaxation (and sometimes a bit of sedation), following which they were returned to the front.

After the war, Dr. Beacham returned to Baltimore. The former chief of geriatrics and chronic medicine at Baltimore City Hospitals (now Johns Hopkins Bayview Medical Center) and a past president of the Maryland National Guard Military Historical Society, he goes to his office at the hospital every day to attend to administrative duties. In 1995, he returned to Normandy, spending most of his time in St. Lô.

His bumper sticker states: "I Did D-Day."

Mary Ann Ayd

Source: Beacham EG. Personal interview, June 15, 1995.

impregnated uniforms had to be worn until fresh uniforms became available several weeks later. Food at first was D rations (fortified chocolate), K rations (concentrated foods), and C rations (canned foods) reminiscent of World War I. Beans, stew, hot dogs, and biscuits were the main diet until unit messes could get organized and more normal rations could come through the pipeline.

A division surgeon (lieutenant colonel) on the staff of the division commander (a major general) was responsible for overall medical service. His staff included a medical inspector, dental surgeon, and administrative assistants. Each of the three infantry regiments had a regimental surgeon (major) with two physicians as battalion surgeons for each of their three infantry battalions. Two dental officers were assigned to each regiment.

The medical battalion came under the division surgeon for general medical purposes but was in the command channels to coordinate the medical casualty evacuation plan. The battalion was divided into headquarters, a clearing company, and three collecting companies.

Division Artillery had a headquarter surgeon and surgeons for each of the four artillery battalions. The engineer battalion and special troops each had a surgeon. Other units attached to the division had physicians attached to them, and activities were coordinated under the division surgeon.

Frontline care

Most frontline medical care was given by company aid men working with each infantry platoon. The aid men used field dressings, tourniquets, morphine syrettes (1/4 grain), Thomas splints for fractured extremities, and limited bottles of blood plasma for use in aid stations.

Each infantry battalion had aid stations set up 2 to 800 yards behind the front lines. Wounded men were brought to these stations, which were usually in tents and later in abandoned houses or buildings. Litter-bearer squads of two to four men furnished some transportation; more was done by quarter-ton jeep ambulances. After physicians and technicians sorted out casualties and quick care, they transferred men needing further evacuation by three-quarter-ton ambulances or quarter-ton jeeps to collecting stations of the medical battalion. Most were then routed to division clearing stations several miles from the front lines and as centrally located as possible for the two or three collecting stations.

Physicians took care of the more seriously wounded, made triage decisions on who, when, and where to evacuate. Speed of evacuation was most important, along with communications by telephone, radio occasionally, and even by runners. Dressings, splints, tourniquets, morphine, and sulfonamide were major items used.

At times, military action precluded casualty flow, but this was seldom, and the medical facilities seemed to expand to fit the situation. Medical replacements were available, but the flow forward did not always keep up with the rearward flow.

In the clearing station, seriously wounded patients were given support and then evacuated by ambulances or trucks to evacuation hospitals. These hospitals could support one or two divisions and were set up to leapfrog to keep pace with advances in the front line. In addition, field hospitals were set up alongside divisional clearing stations to take care of problems such as head and chest wounds or casualties requiring urgent blood transfusions. Few blood transfusions were given in the 29th Division Clearing Station from June 1944 to January 1945.

Behind the evacuation hospitals were large general hospitals supporting corps and armies. These types of hospitals were landed as the invasion force built up. Eventually air and cross-channel ship transportation allowed movement to hospital centers in England.

Casualties

Battle casualties in invasion units were high. It was said of the 29th Division (frequently by its own men) that "one division of 20,000 was fighting, another division was in the hospitals, and another full division in the cemetery." In fact, about 5,000 division men were killed in action or died as the result of wounds by the end of combat May 3, 1945. This number does not include the many deaths among troops attached during various phases of action.

More than 500 casualties were evacuated from the beaches before the division clearing station was available. From mid-June to December 1944, more than 18,000 battle casualties were seen in the clearing station: 2,878 in June, 6,322 in July, and 4,741 in August 1944. Most were lower-extremity wounds, followed by head and neck wounds, then by abdominal wounds.

During the first four months, almost 3,000 men were evacuated with combat exhaustion—more than 1,000 in June alone. Few soldiers in invasion units had an opportunity for relief from fighting during the early weeks and months.

The constant stress of battle and the high rate of casualties combined to take their toll. Later, units were pulled out of frontline activity fairly regularly for an opportunity to rest and relax.

Divisional clearing stations in combat had an expectation of 375 casualties per day, with a maximum of 900 casualties for a 3-day period. From July 30 through August 1, 1944 (during the breakthrough after St. Lô), 2,100 casualties from the 29th and adjoining divisions passed through the 29th Division Clearing Station (104th Medical Battalion).

Major military medical advances in World War II over World War I were speed of evacuation of the wounded, antibiotics (particularly sulfonamides and penicillin), and use of blood and plasma transfusions. On the other hand, weapons were larger and more numerous and explosives vastly more damaging.

Later wars have further increased speed of evacuation with wide use of helicopters. Triage of casualties has improved, and newer antibiotics and vaccines have helped control infectious diseases and wound infections. Soldiers wounded in combat have a better chance than ever of returning home.

On June 10, 1984, at the Fifth Regiment Armory in Baltimore, Maryland, a monument to commemorate the 40th anniversary of D-Day was dedicated to the brave men of the 29th Division who took part in that historic battle.

(Adapted from Beacham EG. Fortieth anniversary of D-Day June 6, 1944, a physician remembers. *Md State Med J* 1984;33:450-453.)

Ed. Note: Dr. Beacham served as 175th regimental surgeon and also as division surgeon with the 29th Division. ■

Brig. Gen. Robert C. Kimberly, M.C.

With the 29th Infantry Division for about one year in Baltimore, Capt. Robert C. Kimberly later was ordered to Trinidad, where he was company commander with the 41st General Hospital. Until his arrival, although 40,000 troops were stationed in Trinidad, they had no surgeon. Among his other duties, Capt. Kimberly taught jungle survival; one of the battalions that later served with Merrill's Marauders in Burma went through the Army's school there.

From Trinidad, Capt. Kimberly went to England, where he served as chief of surgery with both the 97th and 110th general hospitals. He later served as chief of surgery with the 305th General Hospital in France and Germany.

Compared to World War I, moving surgeons close to the front lines was perfected in the European theater during World War II. Until 1942, military politicians had served as Surgeon General. Unlike his predecessors, however, Surgeon General Kirk was an accomplished surgeon. He made it a military offense to close most types of wounds until the soldier had been evacuated to a general hospital. Instead, the wounds were to be packed and left open. Abdominal wounds were common, and Capt. Kimberly often received patients who had had colostomies performed in the field; when they were done well, the soldier's chances were good.

Another lesson learned ("war is a great laboratory") was that blood cannot be left in the chest: a shell fragment larger than 1½ cm had to be removed. "We learned to stop the heart briefly, before the days of heart/lung machines."

For Capt. Kimberly, amputations were the most difficult. "You hated to have to do it, and there was no opportunity for follow-up. With war surgery, a little bit is enough."

As the Allied push into Europe continued into the winter of 1944-1945, the incidence of trench foot began to increase. Although the British had learned to treat it during World War I, they had not shared their knowledge with the American physicians, primarily because, as Capt. Kimberly was told, "You Yanks never asked." Capt. Kimberly learned their methods (primarily physical therapy for cases not too far advanced) and was sent on a special mission to France and Belgium to teach others.

Toward the end of the European campaign, Capt. Kimberly began to receive more patients who were German prisoners of war. Only two cases thought to be tetanus occurred among U.S. troops; one was in a new soldier whose injury occurred before he had developed immunity; the other turned out to be polio. Capt. Kimberly saw 20 German prisoners with tetanus. He learned that the Germans had given tetanus antitoxin only to members of the Luftwaffe and SS. He also learned from captured German physicians that the state of their medical knowledge had quickly become antiquated; they knew nothing about penicillin and little about asepsis or resuscitation. Under Hitler, most of Germany's excellent Jewish physicians had fled or been killed.

Now retired, Dr. Kimberly lives in Baltimore.

Mary Ann Ayd

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Kimberly RC: Personal interview, June 28, 1995. ■

PRISONER OF WAR

. . . . . .

Louis H. Tankin, M.C.

I was in the Reserve Officer Training Corps at Johns Hopkins. I had been a reserve officer in the 66th Light Tank Battalion, but because I had a medical degree, in 1941 I was ordered to resign my commission as a combat officer and accept one in the medical corps, which I did.

Just before the attack on Pearl Harbor, I received orders to report to the Station Hospital at Edgewood Arsenal on January 12, 1942. I remained there until August, when I was ordered to the Second Armored Division ("Hell on Wheels") at Fort Bragg, North Carolina, to serve as an assistant battalion surgeon. I practiced amphibious landings in the Chesapeake Bay, then was shipped to North Africa in November 1942. We landed, as part of the task force commanded by Generals Harmon and Patton, at Fadala during the brief resistance put up by the Vichy French at Casablanca. Fighting was severe in Tunisia and we lost a large part of our force. With the defeat of the Axis army in North Africa, however, the Allies prepared for an invasion through Sicily and southern Italy. My battalion remained in Oran, Algeria, where I was promoted to battalion surgeon.

In early November, we embarked for England and landed in Scotland. Trains took us to Tidworth in southern England, where we were reunited with the 3rd battalion of our regiment on Thanksgiving. In England, we trained from December 1943, until the Normandy invasion on June 6, 1944.

The night of June 5, we saw the planes towing as many as three gliders each toward the channel. We knew this was it. We moved out the next day, but it took us another day to load our equipment on the LCT ships and the heavy weather held us up one more day. I was reassigned to small landing craft that bounced around in the channel for a day. I was lucky. The LCT I originally was to take struck a mine and most of the officers aboard were killed.

Our landing was easy, and we went into bivouac and reorganized. We were ready to move out on June 20 when about 4:00 a.m., our battalion headquarters and my aid station were hit by two 1-ton bombs. There were 15 killed and 45 wounded from my battalion. My left leg from the shirttail to the ankle was badly mashed by fallen earth and stones. Although no bones were broken, the leg was a massive hematoma. I was sent to a field evacuation hospital near the channel. Our division surgeon visited me and asked me to try to rejoin my battalion. I signed a waiver and was carried back to the battalion. My commanding officer took one look at my leg and ordered that I be taken to the 48th Medical Battalion of our division. I could not move my leg because the blood vessels were badly injured and all the muscles were damaged. After six weeks, I asked to be released to join my battalion. My mail had accumulated and I took it with me. It was unfortunate that I did not have time to go through it.

While my injured leg had been more or less healing, my battalion had been in close combat with the Germans and had driven them back with great losses. I evacuated wounded and dead as we began an advance on August 1.

On August 4, my battalion commander called me to headquarters and said, "We have three tanks hit up ahead, and there are wounded men. The enemy is counterattacking and the men are cut off. I want you to go in and get them. You have 15 minutes because I am calling for both artillery and air support to knock out those guns." I saluted and turned away, muttering to the sergeant major, "My next address is Stalag 12." A counterattacking enemy lets no one through, not even a doctor.

I returned to my detachment and explained the situation, including the probability of not coming back. The entire detachment volunteered. I picked two single men with no responsibilities. We drove about a mile down the road and saw a group of our tanks. We drove about another 50 yards when Germans came out of ditches on both sides of the road. One was preparing to throw a grenade, but my driver pinned him with our jeep. Our own artillery shells started to fall and we were forced to run to the enemy rear. My driver, my aidman, two tank men (one wounded), and I were taken to German headquarter areas, along with my dispatch case, which contained, among other things, my mail. Our captors were the 17th Panzer Grenadiers.

In my dispatch case, an officer found a statement from the Associated Jewish Charities. He said, "You are a Jew?" When I answered, "Yes," he said, "No, Jews don't fight." Pointing to a tree, I said, "See the leaves? That is how many Jews are coming to fight you." He immediately ordered his men to take me to a barn, where they stood me against the wall and aimed their rifles at me. Enraged, I shouted to my aid man and driver, "If they shoot me, let the unit know." The officer ordered his men to lower their guns.

During one of the train's stops, a German medical officer who spoke English came over to where I was trying to treat the wounded prisoners. He was more interested in military information than the condition of the men, and he said that with the German V-2, the war would soon be over. I said we had plenty of V-8 in six different models. Unaware that I was referring to Ford automobiles, not rockets, he hurriedly saluted and marched off. I was sure he intended to carry this important bit of information to headquarters.

The next morning we were put in a prison truck with a group of British soldiers. The trucks had white flags. Part of the convoy included tanks covered by large sheets of canvas painted white with red crosses. The first truck carried the German officer in command of the convoy and another group of American prisoners. I was in the second truck next to an Air Force major who had been shot down. We were going through woods when American fighter planes flew over us. The major said the pilots were not fooled by the red crosses and would shoot as soon as we hit a clearing. Sure enough, as soon as we were in the open, the planes came back and strafed the first truck, then banked for another run. I started waving and shouting. The lead pilot had his cupola open, saw us, waved, and pulled up; the rest of the planes followed. He was so close I could see the gold rims of his sunglasses. I was then ordered out to examine the casualties. Some were severely wounded and two were dead.

Later, both British and American prisoners were taken to a Paris railroad yard where we were loaded into boxcars. The

next morning, I was ordered to examine a G.I. of the 101st Airborne who was lying on his belly, shaking and moaning. When I turned him over, he said, "Dr. Tankin, what are you doing here?" Before the war, he had been one of my father's patients in Baltimore. He had been captured on D-Day and was ill with malaria. I convinced the commandant that the sick man had to be hospitalized. Before I was taken away, however, I bent over the G.I. and whispered, "When you get to the hospital, find a hiding place. Our men are only a few days away and the Germans are evacuating. When you get home, let my father know where I am." He did.

> The Germans periodically made unannounced inspections of our barracks. One night, the guards dug up a large box, which the old German commandant ordered opened. A smaller box was inside, and inside that, an even smaller box. This continued until there was only a wooden match box left. The commandant, now impatient, yelled, "Open it!" Inside was a slip of paper. The commandant ordered an English-speaking captain to read it, who did so, then glanced at us with a very worried look. When the commandant asked him what it said, the major replied, "Oh, nothing, my colonel." Striking his thigh with his walking stick, the commandant thundered, "What does it say?" The captain rolled his eyes to heaven and answered, "It says, f--- you."

We detrained after five days in the boxcars. We had had no water for two days, and temperatures were high. We had been packed in so tightly that we had to take turns standing. When we were allowed off the train, some men collapsed from dehydration. We were then marched to a stalag, where I developed my first episode of phlebitis in my injured leg. It was swollen, some clots in the vein had broken off, and I had a severe high fever and chills. I do not remember being taken to the infirmary, but when I regained consciousness, I realized my bed of straw was in a wooden box. The lid of the box was on the floor. The box was a coffin.

At another camp with British and American officers, we were being readied for yet another move. Another medical officer said he would stay at the camp to see the incoming prisoners, so I left with those being moved. The officer who stayed behind was killed when American bombers struck the area.

In September, I eventually arrived at Oflag 64 in Poland. The bunks were comfortable, we had a small infirmary run by two 101st Airborne medical officers, and we got nightly news reports on our clandestine radio. However, as the Russians advanced from the east and the Americans and British from the west, Red Cross supplies and food became scarce. We had two potatoes and a seventh of a loaf of bread per day. On Sundays we received some meat, but it could be from any part of the horse. On one occasion we had the head. From Thanksgiving to Christmas we received no Red Cross parcels.

On January 2, I had a recurrence of phlebitis and was in the infirmary for about 10 days. It was rumored that the Russians were approaching rapidly. The German commandant notified our senior officer that all POWs would be marched back to Germany before the Russians arrived. However, a number of men were too sick or severely wounded to travel. With them, I was left behind. The road outside was choked with vehicles and people fleeing the approaching Russians. The camp was a lonely, empty place to those of us who remained.

We drove all day and saw Russian troops moving west. We saw a woman walking in the snow, carrying a dead child. We saw a regiment of Mongol cavalry trudging through the snow leading their ponies. They had icicles on their beards, horse hide coats, and felt boots. One officer rode a Bactrian camel. This must have been what it was like when Genghis Khan invaded eastern Europe.

When the Russians arrived at the camp, an officer told us that we would be going to Moscow. We were told to get ready and to take the least amount of personal belongings. The trip was slow because the roads were clogged with troops moving toward Germany. It was cold and snowy, and we only went about 20 miles the first night. We slept in the trucks. The second night, we were told that the people in the Polish village would take us in. They did, but it was obvious they were afraid of us and the Russians.

We arrived in Warsaw at the end of January. The next day, we continued on to Rembertow, where the Russians had taken over a former military barracks and headquarters for Polish cadets. It was packed with former slave laborers, concentration camp prisoners, and POWs from the United States, England, France, and Norway. There were also twelve Italian generals who were held by the Germans when Italy surrendered, and an old Yugoslavian count (all were in their 60s and 70s).

We held sick call each morning. It was an international affair. We did not have much in the way of medical supplies because the Russians were very poorly equipped. We evacuated some people to a Russian general hospital that consisted of several large buildings. One day, the hospital commandant invited several of us to tour the hospital. During a briefing in his office, I asked if there were any cases of typhus. He said no. The officer then took us to various buildings that housed surgical and medical patients. We passed by one building, but did not go in. When I asked why, the officer replied, "Typhus."

I spoke to a woman physician who had studied in Germany and France before the Russian Revolution in 1917. She said the medical care was very poor and primitive and that they had few medical and surgical supplies. They knew about sulfanilamide, but had none. She showed me a page from a very old book taken from a monastery. Medical orders had been written between the lines because they had no other paper.

We remained in Rembertow more than two weeks. There was no transportation available and no definite assembly point for POWs. We did not then know that the Russians were using us as pawns in their negotiations to have their own POWs released.

We were finally put in the boxcar of a train headed for Odessa. Although we had blankets and a wood stove, crossing the Ukraine in winter was cold and desolate.

In Odessa, we were marched to a camp near the water. It was surrounded by barbed wire and had guards with machine guns in the towers. The quarters were villas of the foreign government ambassadors from the time of the Russian czars. I was billeted in the pagoda of the Japanese ambassador. The rooms were completely empty. We were each issued one spoon. Two men, however, had to share one blanket and one bowl. When we complained of the cold and lack of fuel, we were told that we were in a warm climate. There was very little to cook.

One morning I was standing on the steps to the main building at Rembertow when I saw a line of men in uniform wending their way down a snow-covered hill. They looked like dwarfs or midgets walking with a peculiar gait. As they came closer, I saw that they were amputees with boards on the stumps of their legs and blocks of wood strapped to their hands to help them move.

One day there was considerable excitement in the camp. A transport ship had arrived and the men were to be ready to march out the next day. One of our officers asked if I would stay until the next group of POWs arrived, since I had been so adept at learning the ropes of the camp. I did not want to, but agreed on the condition that I would leave on the next ship.

Later that night, a soldier came to see me. He was terribly upset because the Russians had discovered that his parents had fought against the Bolsheviks in 1917, then fled to Manchuria, where he was born. Although he was now a naturalized American citizen, the Russians told him they considered him a Russian citizen and were not going to let him leave in the morning. I told him our men would fall in marching order before daybreak. I told him to button his coat up around his face, pull down his cap, fall in the center of the column, and keep looking down when they marched out. He did and got safely aboard the ship.

It was a very lonely feeling as I stood in the center of the compound as the sun began to rise—the only Allied soldier in the camp, surrounded by machine guns, barbed wire, and guards. Another group of Allied POWs soon arrived, however, and I was kept busy. A young medical officer who had arrived with this group agreed to stay so that I could leave on the next ship.

After Oflag 64 was evacuated of all but the sick and wounded, some of the remaining fellows got into the German headquarters building and storage house. They found a safe, cracked it, and returned with duffle bags full of German marks and other money taken from POWs. We had no toilet paper when we left the camp and so used a lot of the money on the long trip to Odessa. When I arrived in Naples, I learned that all German and Austrian marks issued prior to 1932 could be exchanged for Allied currency. How many can claim to have used several thousand dollars as toilet paper?

I finally left Odessa aboard the *Duchess of Bedford*, a former Canadian Pacific Line cruise ship that had been quickly armed and camouflaged when war broke out. The ship's captain gave us a welcoming dinner that was like a banquet. After dinner, I took a stroll around the deck. Two British officers looked at me very seriously each time I passed them. Finally, one said, "I say, old chap, what the hell nationality are you? I have never seen a damn uniform like yours before." His question was justified. I was wearing a Russian cap with captain's bars, a Scottish sweater I had found at Oflag 64, a French cavalry coat, and a British battle jacket. The only American parts of my "uniform" were my pants and the boots my wife, Ruth, had sent to me in North Africa.

We sailed through the Dardanelles to Malta, then to Sardinia and Corsica, and finally to Naples. We were asked if we wanted to try to rejoin our outfits (mine was already at the Elbe, linking up with the Russians). I chose home, although there was no guarantee I would not be reassigned. The trip from Naples was almost uneventful—as we were headed up the coast to Boston, three U.S. antisubmarine destroyers were dropping depth bombs on or around a German submarine off Sandy Hook.

We disembarked, called home, filled up on chocolate milkshakes, and boarded an all-night train for Fort Meade. Ruth met me there at the post. I had said goodbye to her at the harbor port in Baltimore in October 1942. It was now April 1945.

I feel my experiences between 1941 and 1945 gave me the ability to understand others and their problems, to expect great things from people, but also not to be surprised by the horrible things they can do to each other. I saw inhuman treatment and dastardly destruction. I also saw compassion and magnificent sacrifices.

A piece of bread, a blanket and shoes, the sound of laughter and the chatter of children. The look in the eyes of both young and old. A feeling of security. These are the things we take for granted until the day they are no more. ■

Andrew E. Mance, M.C., was called to active duty from the U.S. Army Reserve in April 1941, reported to Fort Meade, and ended up in charge of the dispensary there when the commanding officer was transferred to the Aleutian islands. Promoted to major, in 1944 he was ordered to the station hospital in Valley Forge, Pennsylvania, given a two-week course in urology, and placed in charge of the urology section. In August, he was ordered to England, where he served first at a station hospital near Liverpool, then at Duke General Hospital and the 23rd General Hospital. In addition to his urological duties, he was pressed into service as an anesthesiologist, again with minimal training. Although most patients received at the station and general hospitals already had been stabilized, Maj. Mance treated many with shrapnel wounds from which metal had to be removed. Among his most memorable patients was the soldier he asked his commanding officer to send home because the man had lost one testicle. The commanding officer replied, "Well, others have lost their lives." The soldier was returned to the front.

After the war, Maj. Mance returned to Fort Meade, but preferring the life of a country physician, declined the Army's offer of a promotion. He and his wife returned to Oakland, Maryland, where he has been in the general practice of medicine since 1946.

MARY ANN AYD

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Mance AE: Telephone interview, August 29, 1995. ■

Lt. Marvin J. Rombro

In 1943, Marvin J. Rombro entered the U.S. Army Air Force as an aviation cadet. He was sent to Greensboro, North Carolina, for basic training; to Santa Ana, California, for pre-flight training; to Nashville, Tennessee, for psychological testing; to Las Vegas, Nevada, for six weeks of gunnery school (passing meant being able to take apart and reassemble the gun blindfolded); and then to Victorville, California, for three months of bombardier training. Commissioned a second lieutenant, he was—after more training in Nebraska and Idaho—finally ordered to Massachusetts, where he boarded the Coast Guard vessel *Wakefield*. ("I was seasick for 18 hours. I learned then why they call it the *head*: you don't know which head to put in first.") He arrived in England on Christmas Eve, 1944. He was with the 8th Air Force 34th Bomb Squadron.

Lt. Rombro flew in 16 missions over Europe as the bombardier in the nose of a B-17. At first, the crews flew five days in a row; later, they flew a mission every four days. "I was lucky. I came home to a warm meal every night. We did play a lot of bridge, however."

Escorted by 3,000 fighter planes ("so there wasn't too much flak"), 2,000 bombers made for a proficient operation. The duties of the bombardier lasted about ten minutes during the mission, while the plane was in range of its targets. Lt. Rombro's last bombing mission was over Berlin. His final mission, however, flying at an altitude of about 400 feet, was to drop rations in Holland, where the people were in danger of starving. Lt. Rombro was awarded the Air Medal with two clusters, the European Theater Medal with two clusters, and a group commendation.

After V-E day, his crew flew their B-17 back from England. He arrived home June 22, just in time for the birth of his first child.

Lt. Rombro had always wanted to be a physician, but had finished only 18 months of college before the war. Still in uniform, he accompanied a friend to Bucknell University, where a school official mistook him for a late-registering student and propelled toward a classroom. He stayed. When he finished, the education benefits of the G.I. bill allowed him to consider medical school.

A 1951 graduate of the University of Maryland School of Medicine ("everyone in the class was a veteran), Dr. Rombro has been a family practitioner in Baltimore for 42 years.

Mary Ann Ayd

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Rombro MJ. Telephone interview, September 11, 1995. ■

IN MEMORIAM

John David Young, Jr., M.D., a captain in the U.S. Army Medical Corps who served with the 122nd Evacuation Hospital at the Battle of the Bulge, died September 10, 1995, of complications of Alzheimer disease. Born near Uniontown in Carroll County, Dr. Young was a 1941 graduate of the University of Maryland School of Medicine. From 1941 to 1942, he interned at Maryland General Hospital, where he also completed a surgical residency in 1944. He completed a residency in urology at the University of Rochester Medical Center in 1950, then returned to Baltimore, where he began private practice. He established the residency program in urology at the University of Maryland School of Medicine and served as the head of its urology division from 1956 until his retirement in 1987. Dr. Young was the first urologist in the United States to report the use of preoperative radiation in the treatment of bladder cancer. He is credited with discovering the relationship between hypertension and renal disease, and he pioneered techniques in the treatment of testicular tumors and adrenal surgery. Certified by the American Board of Urology, he belonged to numerous professional organizations, including the American Association of Genito-Urinary Surgeons and the American Urological Association. Dr. Young was 78. ■



England, 1943.

Troops and medical officers donning gas masks during chemical warfare training exercises.

Photograph courtesy of Isadore Kaplan.

An Itinerant Medical-Military Odyssey

Isadore Kaplan, M.D.

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In AUGUST 1938, I BECAME INtrigued by the appeasing tactics of England's prime minister, Neville Chamberlain, who was threatening Adolf Hitler with strong rhetoric and the brandishing of his notorious, stiletto-like umbrella. Anticipating full-fledged war on a worldwide scale, I enlisted as an inactive first lieutenant in the U.S. Army's Reserve Officer Training Corps (ROTC).

Under pressure by its European allies, the U.S. Army ordered mobilization of the 29th Infantry Division, a National Guard Organization, effective February 3, 1941. Consisting of personnel from Maryland, Virginia, and Pennsylvania, it was to be stationed at Fort George G. Meade, Maryland. One of its supporting, noncombat units was the 104th Medical Regiment, whose table of organization contained the following roster of Maryland physicians: Commanding Officer Lt. Col. William ("Wild Bill") Triplett; Majs. Henry Buettner and Franklin Eleder; Capts. Donald Cooper, James Nuttal, Robert Kimberly, and William Dunnigan; and 1st Lts. Thomas Hutchins, Mitchell Kunkowski, Bernard Sabatino, and John Urlock. In addition, Maj. William Sinton was a battalion surgeon with the 111th Artillery and Capt. Edmund G. Beacham was attached to the 175th Infantry Regiment (Baltimore City).

On April Fool's Day, 1941, I reported for duty with the 104th, greener than the grass outside our barracks. To my surprise, it was homecoming, for I was reunited with such excompatriots from the University of Maryland School of Medicine as 1st Lts. Benjamin Highstein, Lester Kolman, Albert Kurland, and Gilbert Rudman.

The initial setting was chaotic and incongruous, with a mix of medically trained National Guard officers and inactive ROTC officers unskilled in the ways of the foot soldier. Moreover, the sophisticated professionals frequently became riled when ordered to obey commands issued by one of the Army's "90-day wonders," a second lieutenant recently graduated from Officer's Candidate School. Triage was prompt and radical. Capts. Cooper and Nuttal opted for the Air Force; Capt. Kimberly left for a surgical unit in Trinidad; Lt. Rudman was dispatched to the 28th Surgical Hospital in New Guinea; Lt. Kurland joined the 34th Division in its North Africa operations; Lt. Kunkowski was medically disqualified; and Lt. Roland McDonald was transferred to the infantry as a battalion surgeon.

Despite its shortcomings, with months of drilling and marching the 104th was converted from a regiment to a battalion. It remained poorly trained, however, and failed basic training inspection, necessitating an additional five weeks of hardship—it was tantamount to repeating kindergarten. Following this ordeal, the medical battalion safely convoyed to A.P. Hill, Virginia, for

maneuvers. The location was a desolate, dusty, no-man's land infested with chiggers, the blood-sucking mite Trombiculidae, whose bite produced intolerable itching. The training was helpful, for we learned that there were three different ways of doing things: the right way, the wrong way, and the Army way. William Mauldin aptly coined the term *snafu* (situation normal, all f----- up).

Following varied maneuvers at Morven, North Carolina, and Cheraw, South Carolina, on Sunday, December 7, 1941, we were bivouacked at Fredericksburg, Virginia, on our way back to Fort Meade. Partying on the tailgate of a ten-ton truck, we heard of the Pearl Harbor disaster. It was a shocking and disappointing revelation for the reserve officers who were homeward bound, preparatory to being released to inactive status. Training became more intense. Following the infamous Bataan march, division commander Brig. Gen. Leonard Gerow, a feisty, irrepressible West Point graduate, ordered all officers to take target practice and learn "to kill on sight." With 20/20 vision, I easily qualified for a sharpshooter's medal.

From Fort Meade, the 29th was dispatched to Camp Blanding, Florida, for the winter. Typical of Army rationale, once we were comfortably settled we received orders to "head north" to an unknown destination, which ultimately turned out to be Camp Kilmer, New Jersey. This was followed by embarkment at Hoboken, New Jersey, aboard the troopship *Queen Elizabeth*, which was no longer a luxury liner. The trip to Scotland was temporarily disrupted in mid-Atlantic by a sudden, dull thud that caused the lady to list and change course. Once in safe waters, Brig. Gen. Gerow advised his troops that the ship had been grazed by a U-boat torpedo, but had escaped unscathed. However, most of the accompanying Liberty ships, which were transporting the division's equipment and supplies, were destroyed. As a result, after settling in various parts of southern England, the ground troops had no rifles or artillery. To confuse the enemy's air reconnaissance, fighting troops were temporarily dispatched to patrol the eastern coast of the British Isles using broomsticks as an effective substitute for guns.

For the 104th Medical Battalion, in which I was now a captain, the wandering continued. We located at Tidworth for six months, followed by a short stay at Chattlewood, Plymton, across the river from the city of Plymouth. While stationed there, during the zenith of Nazi Luftwaffe bombings, the air raid siren screeched ominously and from our barracks we leapt into nearby slit trenches. It was an eerie, awesome sight watching Plymouth burn; even more frightening, as we shivered and cowered on the ground, our tympanic membranes were being numbed by the staccato of the Nazi planes' machine guns tattooing the tin rooftops of our adjoining buildings.

From Plymton, we bivouacked briefly at Dartmoor (next to the prison) and finally settled at Bodmin Moors amid the heather interspersed in the barren soil, which precluded any extended foot movements. Just before D-Day inva-

After 50 years of meditation, with a sense of poignant nostalgia, I feel obligated to remember both the deceased and their survivors. Respecting military protocol, all medical officers listed below are identified with their highest military rank.

Taps have sounded for Brig. Gen. Triplett; Lt. Cols. Eleder, Buettner, and Aubrey; Majs. Sinton and Rudman; Capt. Sabatino, for whom a memorial plaque hangs in the hallway of Davidge Hall, University of Maryland School of Medicine; Capt. John Williams, also killed in action; and Capts. Highstein, Kolman, Roberts, and Heffner.

For the survivors, a lasting kudos until the final reunion: Brig. Gens. Nuttal, Beacham, and Kimberly; Lt. Col. Cooper; Capt. Kurland, who was awarded two bronze stars and the legion of merit; and Capt. Urlock, retired, but still the national surgeon for the 29th Infantry Division.

Ed. Note: Isadore Kaplan, M.D., is a major in the Medical Corps, Honorary Reserve, U.S.A. He retired in 1977 as the medical director for the Chessie System of Railroads. He is a research consultant at Taylor Manor Hospital in Ellicott City, Maryland.

sion time, Capt. Highstein was transferred to the 42nd General Hospital; Capt. Urlock also left the 104th; and as a promoted major, I was placed on detached service with Headquarters Gen. Eisenhower ETOUSA (European Theater of Operations United States Army), under jurisdiction of Col. Fleming at Tavistock, England. It was a unique assignment in which I was being groomed to replace the colonel as the ETO's head of chemical warfare medicine.

Considered an expert in all aspects of the use of chemicals such as lewisite, nitrogen mustard or phosgene (carbonyl Cl), at an inspection of the 92nd Gas Treatment Battalion at Dudley, England, in February 1944, I experienced the most unexpected incident of my military career, involving the battalion's unknown plans and training officer. The officer was replete with apprehension and anxiety since he had worked diligently to impress successfully the "major from ETO." On our meeting face to face, he paled, dropped his lower jaw, and—almost speechless—exploded with expletives that shook and dismayed his commanding officer. The surprised Pand T officer was Capt. Albert Steiner, my very close friend and medical school classmate. Regaining his composure, he proudly advised that the battalion had just passed its inspection. Shortly thereafter, I was visited at Tavistock by Capt. Morris Steinberg, another Baltimore physician, who was with the 53rd Medical Battalion of the 5th Army Corps at Exeter.

Although I did not rejoin the 29th Division during its invasion of Omaha Beach on D-Day, its medical units, including the 104th, performed admirably, as described by Dr. Beacham (see page 953). Two of its Baltimore physicians, Capts. Sabatino and Williams, were killed in action. Another Maryland officer, Capt. Kolman of Company C, overran his military cover on D-Day and was captured while still in his ambulance. He was retained as a prisoner of war by the Germans for precisely 58 days—just two days short of providing the captain the automatic honorable discharge that was granted to those held prisoner 60 days or more. ■

Capt. Robert R. Cross, M.C., served in Europe with a gas treatment battalion of the 3rd Army. Of the 1,000 men in the battalion, approximately 25 were medical officers. Because the Americans wanted to be thoroughly prepared if chemical weapons were used, gas treatment battalions underwent highly specialized training. They carried medications that were supposed to be antidotes and decontamination equipment, including portable showers. When it eventually became clear that chemical weapons probably would not be deployed, Capt. Cross and others were allowed to set up their equipment so that soldiers from the front lines could get a hot shower—an almost-unheard-of luxury.

During lulls between battles, the gas battalion physicians were detached to serve as ward officers in evacuation hospitals. In an apartment building in Thionville, France, they opened a hospital designated to receive trenchfoot casualties. Having neither the training nor supplies to treat the problem, they had to transfer those who did not improve to a station hospital. Their hospital later was designated to receive battle fatigue casualties, and "then we all became psychiatrists, dispensing barbiturates according to the Army schedule." When a crisis such as the Battle of the Bulge ensued, however, they were immediately withdrawn from detached service because it would have been foolish to risk the decimation of a unit with so much specialized skill. "Fortunately, we never had to use our chemical warfare training."

Dr. Cross, a retired anesthesiologist, lives in Rockville, Maryland.

Mary Ann Ayd

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Cross RR: Telephone interview, September 21, 1995. ■

The 56th General Hospital

Marion Friedman, M.D.

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In 1943, SEVERAL BALTIMORE physicians volunteered to form an Army hospital unit. They were not sponsored by anyone, however, and met with little success locally. The Office of the Surgeon General of the Army learned of their patriotic gesture and advised them that a new unit was being formed under the command of Lt. Col. Daniel S. Sheehan, a regular Army medical officer from Columbus, Ohio.

Benjamin H. Rutledge, M.D., of Baltimore was assigned as chief of medicine and was later assisted by Maj. Donald Woodruff, also of Baltimore. Along with Capt. Joseph E. Moore, M.C., they were ordered to Fort Jackson, South Carolina, to be prepared for overseas duty. After many delays, they proceeded to Camp Shanks, New York, a staging area for shipment to the European theater. Instead, they were alerted for "immediate" embarkation for North Africa. Although they were ready by August 17, orders never arrived. Instead, with five other groups, they were removed from the state of alert and sent to Fort Devens, Massachusetts, at the end of August. They received sailing orders on October 8 and the group left Boston abroad the *Mauretania*. The ship was so crowded that they were divided into two sections and alternately slept in bunks and on the floor. Arriving in Liverpool, England, ten days later, they were immediately placed in two hospitals to care for hundreds of casualties arriving from North Africa via Bristol.

Around mid-April 1944, they were ordered to operate as dispensary teams in marshaling areas and given special training to prepare them for the strenuous life ahead. The 56th was not actually scheduled to arrive in France until D-Day plus 45 days. They landed on Utah beach near Montebourg on July 24. As the war carried our forces further inland, they followed.

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A 1916 graduate of The Johns Hopkins University School of Medicine, Joseph Earle Moore, M.D., was a member of the U.S. Army Medical Corps in both world wars. During his service in World War I, he became interested in venereal disease. When he returned to civilian life, he entered private practice with Albert Keidel, M.D., who had founded Department L at Hopkins. In 1929, Dr. Moore became physician-in-charge of the department. Under his leadership it became one of the foremost venereal disease clinical and research centers in the world, and the majority of the venereal disease control officers in World War II were trained there. From 1940 to 1945, Dr. Moore was chairman of the Subcommittee on Venereal Disease Control of the National Research Council. He also served as a consultant to the Surgeon General of the Army from 1943 to 1950. For his work in venereal disease control during World War II, he was awarded the Medal of Merit. Dr. Moore died in 1957.

With the 123rd Evacuation Hospital in France and Germany

Col. John B. De Hoff, M.C.

On the *Brazil,* nine of us medical officers occupied one cabin made for two people on holiday. The cabins were now filled with three tiers of bunks three high, nine cork life preservers, and nine clumps of gear: pack and extra shoes in a blanket roll, gas mask, steel helmet, and winter clothing. We were one of 80 ships in a convoy maybe eight or nine columns wide, with destroyers all around. During the day, North Atlantic gales whipped the tops off the waves and sent the water droplets scudding across the ocean. At night, the ships kept in line, but all that could be seen from the decks was a blue light on the back of the vessel in front or on the front of the one in back. In two weeks at sea we took one bath because the tub would fill with sea water. It was January 1945.

Our convoy was the first to land at the port of Le Havre, at that time under hurried renovation. The 123rd Evacuation Hospital made camp at Lucky Strike, one of three staging areas (all named after a popular cigarette brand) just opened in that area for initial receptions. They were located about four or five miles from St. Valery en Caux, a small town on the French coast. Lucky Strike was sited on a former German airfield.

Five officers occupied each pyramidal tent, heat for which was provided by a small, French-invented, coke-burning stove. It took us a while to learn that coke has to be burned deeply, not in shallow coals. When it did burn successfully, it got so hot that now and then a tent would burn down. When tents were not burning down, they were blowing down.

The day after we arrived we received casualties. Troops from ships in our convoy had been on a train to St. Valery en Caux, where the station was down a hill and at the end of the line. The train's brakes failed and it piled into the small brick station, killing about 165 men and severely injuring an equal

St. Valery en Caux had the usual small French bars. At a larger one in a hotel, a woman at the cash register, when quietly asked by a soldier, "Ou y a t'il le lavabo," would loudly repeat the query to a waiter. He in turn would shout the question to a person at the far end of the bar, who would yell it out more loudly still, then reach under the bar and lift up an old-fashioned pot. Only when everyone in the bar was laughing would the crew point the way to the *pissoir* that was up the steps and down the hall.

number. Being without medical equipment, we could do little or nothing and had to reroute the survivors to several active medical units in the area.

Our latrines initially were entirely open and only casually surrounded by a canvas shield. Over this screen one could survey the camp while seated on the four-holer, or even return a greeting to an occasional nurse who might pass by. The necessary holes had been cut with a vertical saw and had sharp edges. Each box had been sealed at its base with dirt piled up against the boards. This dirt became a hill. Rain caused it to freeze solid at night. In the daytime, its surface thawed, which made it a *slippery* hill. One had to back up on it when preparing to sit. Before this, however, there were at least four layers of clothing, both up and down to separate. Then holding them safely together, one backed up to the sharpened hole and fell in place.

After a month of enduring camp boredom, or searching for something to burn in the stoves for heat, or censoring outgoing mail and signing each envelope in freezing weather, we departed by bus to board a train for what turned out to be a small chateau at Rethel, just east of Rheims. It took the train three days and two nights to travel the 160 miles, sometimes so slowly that men would hop off the cars and run alongside, just for exercise. We were 28 medical officers in a freight car, with an unsafe wood stove, and straw on the floor. We stopped twice a day.

In a field not far from the chateau, we established the 123rd's first working setup. In the tent assigned to my laboratory, I found 85 wooden boxes of supplies. They were neatly piled, but individually unidentifiable. Sizes ranged from about a foot square to big enough to enclose the kerosene Servel refrigerator. I had the men save everything we took apart so we could make what furniture we needed. We even went scrounging in Army dumps in Rheims for more pieces of things we could use. We wondered who designed the table of equipment for our 500-bed field emergency hospital and gave it only a single set of tools. Scrub basins and rests for litters had to be built, as well as much of the other equipment a hospital would need. I had included my own tools in the lab packages, however, so we were better off than most. From the saved boxes we made counter ends. For counters, we used the sides of the box that had contained the refrigerator. More boards made shelves. We were in such good shape that we never lost a bottle when we moved. That is, we never lost any but liquor bottles.

Army pharmacies came with bonded bourbon available on government issue. To justify a new order, one had only to show the inspecting officer prescriptions for whisky or that unopened bottles had been broken in transit. My sergeant knew how to file off the top of a bottle, transfer the contents to another bottle, and show the unbroken seal if asked. One of the first orders from the commanding officer, who would often entertain, was, "Send all your pharmacy liquor to my quarters!" Resupply was never a problem.

The war came a little closer when we found a pile of steel helmets five feet high and twenty feet in diameter. Each helmet had a single bullet hole.

While we were at this initial shake-down location, a small truckload of eight or so soldiers had gone to Rheims on pass. The driver became intoxicated and overturned the vehicle on the way home, killing himself and my laboratory clerk. Although we were the only available emergency hospital, we had no working equipment yet and the lyophilized plasma just would not dissolve, a story we heard again and again.

In late March, we motored north to a field that came to be known as the Clover Patch, some twelve miles north of Cologne. No tents had been readied for us by the advance party, so the first night we slept on ground that had been casually checked for mines.

The working parts of the hospital, mostly surgical, were all under tentage made of combinations of long ward tents and pyramidals with their square bases. The ward tents could be laced together side by side to create a broad receiving ward, or lined up end to end for pre-op and operative usage. Among the outfits that we served were two all-black quartermaster units that had been a long time without medical care. During our first week in action, I found enough disease to warrant return home for about one patient a day and maybe a discharge.

We were always looking for things others had discarded and were ready to seize German supplies for things we might need. On one trip to Düren, our vehicle was stopped by a bloodied, one-armed German civilian in the middle of the road. He pointed to two friend on a nearby hill, across a field marked, "Achtung!! Minen!!" One was on the ground, the other was standing on one leg. These veterans of World War I had gone exploring across the area, setting off some antipersonnel mines. We were not equipped to rescue the other two, so I gave the one man an injection of a third of a grain of morphine, hailed an Army truck going toward a hospital we had just passed, and asked that the two remaining Germans be rescued. On our way back, we found that an Army tank, several medical corpsmen, and an ambulance were needed to pick up the wounded after first exploding several mines in their paths.

At the Clover Patch, we served as an evacuation hospital for troops holding the Germans in the Ruhr pocket, just across the Rhine. We got an insight into how many people the Germans had lost when we visited the city hall at nearby Bergheim. In 1939, the townspeople had begun using marble plaques to memorialize their lost sons. As the years went on, the plaques were mounted down the hall, then up the stairs and around the landing, and had nearly reached the second floor when we got there. As we traveled around Germany, we saw only old men and young boys available to help the women as families returned their household goods to the places they had vacated as the Allies advanced.

Our next setup was a short one in Solingen, the home of famous cutlery. One of our noncommissioned officers had fled the town with his parents before the war. He knew the bureaucrats and helped tip off Army Civil Affairs about a massacre of civilians that had occurred just before we arrived. The SS troops had wired together about two dozen political prisoners, then shot the victims one at a time. The U.S. Army had Solingen's mayor and other important civilians dig up the bodies and rebury them properly.

Two of our medical staff had their 45th birthdays while we were in Germany. The chief of surgery remarked that, of all his friends, only the physicians had been drafted; other men his age such as bankers, businessmen, and lawyers, were exempt. The other birthday celebrant had served in World War I as an artillery sergeant and had gone through much of the area we were moving through.

One physician, who was said to have been a member of the Philadelphia Symphony Orchestra, had joined the 123rd from a medical unit based in southern France. He had heard the song "Symphony of Love," which was popular on the Riviera. Having liberated several violins in search of one that suited his taste, he performed for us this delightful melody in a cow pasture where we were encamped.

We ended our advance into Germany at Wupperthal, about 25 miles east of Düsseldorf. We occupied the Diakonissen Anstalt Bethesda, a Lutheran hospital about the size of the

> We went through Jülich, where I could stand in my jeep and survey the entire town, flattened, said the sign, "Courtesy of the 29th Division." Later, we drove to the demolished bridge at Remagen, where we could "Cross the River with Dry Feet," courtesy of yet another division. All the bridges across the Rhine were down. We crossed on a ponton bridge named for Ernie Pyle, the respected war correspondent. On one float of the bridge sat a soldier with a carbine and a box of ammunition. His job was to shoot at anything floating north down the Rhine in order to explode floating enemy mines.

original Union Memorial Hospital in Baltimore. Army Civil Affairs saw to it that we employed citizens of nearby Wupperthal, including the civic symphony and its theater and ballet—all as kitchen help. This was done mainly to give them food, which was hard to come by.

Hospital operating suites were designed for at least two operating tables. Surgical equipment was excellent, but their pharmacy had no antibiotics. Various sulfonamides were on hand and many large glass containers of capsules for specific purposes, many compounded with opium. Cupboards showed that the German army had obtained many medical supplies from national depots or military units in Greece, Italy, and France. Bandages and pads were paper. There was no provision for indirect blood transfusion; the only equipment on hand was for donor-to-patient transfusion. Field surgical instrument kits were specially fashioned and equipped, ready to be loaded into sterilizers tray by tray.

Water had to be trucked in because of bombing damage to the conduits. Army engineers rigged up a fire engine pumper to draw water from a nearby pool and pump it into a street hydrant. With the proper control of appropriate valves, the water would flow to the hospital through connecting water mains. Although too dirty for washing patients, it was helpful for flushing toilets and it relieved the Lutheran sisters, who had had to carry water in buckets to clean floors.

When we left Wupperthal, we stopped for several weeks near Sinzig, small town along the Rhine river. Here, we were nearly bombarded by U.S. Army Engineers who were exploding captured ammunition, unaware that the 123rd was bivouacked just on the other side of low hills. When pieces of shrapnel and exploded materiel started landing in our hospital area, the executive officer quickly advised the demolitions teams of the danger we were in and had the explosions stopped. We were grateful that no one was hurt.

From Sinzig, we went to Verdun in France, for what turned out to be several weeks of rest and recuperation. We then moved on to Mourmalon, in France's champagne country, to begin packing for still another voyage—to the Pacific. By then, however, I had accumulated enough points in the Army system that measured duration of overseas duty to qualify for reassignment back to the States. As an erstwhile laboratory officer, I was ordered to the 4th Medical Laboratory in Paris, located on the third floor of the Ecole de Pharmacie close to the Luxembourg Gardens. The lab sorely needed tissue pathologists to process a backlog of surgical specimens. It did not need me, because by then I was but a skilled cookbook lab officer. About the only task I had was to test a sample of each carload of pro-kits, the venereal disease prevention kits for after-action use. With the help of an experienced British WAC, we ran usual official tests of such characteristics as the surface tension of ointments, checking samples of condoms for freedom from leaks, the maximum safe volumes the condoms could endure without bursting, and, finally, the quality of soap and tissues. All of this had been going on elsewhere to help the war effort, but now it was our turn.

Not much celebration occurred when V-E day came around, but one German did ask incredulously, "No more blackout?" Soon thereafter, the public parks in Germany were beginning to show what could be called victory gardens. The people finally found that they had to grow their own food on their own lots if they did not want to starve.

In August, we heard of the Army's "Green Plan" to bring many medical officers, now in excess in Europe, back to the United States where physicians were sorely needed. This was my first air crossing of the Atlantic, and I did it in the company of Paul Carliner, an esteemed Baltimore physician.

Our nation can be thankful that so many capable civilians rallied to help the regular military do jobs for which none of us had been properly prepared.

Ed. note: Dr. De Hoff remained in the U.S. Army Reserves until 1965, when he retired a colonel. Now retired from medical practice, he lives in Baltimore County. ■

WITNESS TO THE LIBERATION

Capt. Kenneth Zierler, M.C.

In April 1945, while battalion surgeon to the 399th Armored Field Artillery, I became, through, no special effort of my own, the first Allied officer to enter a slave-labor concentration camp, Langenstein-Zwieberge.

It was a balmy spring, linden in fragrant flower, birds singing, rolling green hills. There was an air of optimism, relaxation and happy thoughts of going home soon. Headquarters battery and the medical detachment, with the battalion aid station, were set up in a large manor house, about 200 feet long, four stories high, the main house of the estate of the von Rimpau family, in whose kitchen, where the aid station was established, we found centuries-old account books.

In this atmosphere, there appeared on April 17 or 18, I'm uncertain which, a jeep containing two war correspondents, Howard K. Smith, a network radio reporter, and Lou Azrael, from my home town, reporting for the now defunct Baltimore *News-Post*. They told me that there was a concentration camp nearby and that we could liberate it because, they had heard, the guards had fled. It turned out that the guards had fled two days earlier at the sound of our tanks rumbling down the road. They had demobilized themselves simply by changing into mufti and melting into villages. The ambulance driver, Cpl. Henry Mertens, the two newsmen and I took off.

The gate was open. There were no guards. A handful of men, in the vertical striped uniform of the concentration camps, had placed themselves near the gate, but no one had been able to bring himself to cross the line past the open and unguarded barrier to the world outside. As we descended from the ambulance, they kissed our shoes. We lifted them to their feet. These walking skeletons were young men, looking aged. They told us we were the first Allied personnel they had seen.

Some were covered with lice. Their faces were drawn, pale and gray. Most of the living huddled in their huts on cots, too weak to stand. From a tree swung the corpses of two inmates, hanged just days before. No one had the energy to climb the tree and cut them down.

Until the guards had fled two days earlier, they had been working at their job 12 hours a day, digging what was to become an underground factory in the Harz Mountains for Messerschmitt fighter planes and V-2 rockets.

The Nazis had selected the slave laborers from the large concentration camps. They had calculated the economy of slave labor as dispassionately as a packing house calculates how to get the most out of a pig. They gave the men rudimentary housing, just enough food to keep them working and no medical attention. Thus they had the benefit of their labor for about a year at a cost of about a few pfennig a day, until the men died of exhaustion or disease.

Martin Adends, from Amsterdam, age 55, guided us about the camp. He had been captain of a Dutch freighter. When the Nazis overran Holland he joined the underground and participated in acts of resistance and sabotage. He was caught distributing an underground newspaper and ultimately sent to this camp.

Many survivors were barely alive. They showed us a large pit, one of several, covered with earth and lime, containing, they said, about 350 bodies of those who had died during the course of their labors. We were told that most had died of weakness and disease, but that about 50 had been hanged as disciplinary examples.

A Hungarian man was eager to display his back covered with bruises and welts. He said that two weeks earlier he had been beaten by a guard with an iron rod for the crime of eating potato peelings he found on the floor of the guards' kitchen.

Lou Azrael spoke with one 20-year-old, a skeleton of a man who weighed about 80 pounds. His face was green with jaundice, his skin stretched over his taut skull. Lou asked him what his offense was. "I am a Jew," he answered.

Those who were able to walk swarmed about us in a variety of moods, many speaking at once, or trying to. Some voices were so feeble we could scarcely hear them. Some seemed to be mumbling madly. Most blessed us, thanked God, wanted to know when there would be food, when they would go home.

Our aid station could not handle this catastrophe. I was in a hurry to return to base to call division headquarters to send evacuation units for the survivors.

The day after we four entered the camp, two young men, both Polish, walked from the camp to the manor house. They attached themselves to the headquarters battery mess truck. They were skinny and haggard. They said they were 19 but looked like old men. They instantly became mascots of the enlisted men in the headquarters battery.

That afternoon a six-foot German, ramrod straight, dark, knickered and hosed, a Heidelberg scar on his cheek, strode into the courtyard of the manor house. The two Polish survivors were visibly agitated. They kept pointing at the visitor who, in English, demanded to see our commanding officer. He claimed that our soldiers were going into the village of Langenstein, stealing eggs and chickens. Somebody escorted him into the manor house to the colonel.

Our Polish survivors asserted that the visitor was commandant of the concentration camp, the man immediately responsible for the two dead men we saw hanging from the tree, responsible for the miserable cruel existence of the walking skeletons I had seen in the camp. He must be arrested, they said.

I relayed the accusation to our commanding officer. The visitor denied the charge. Our commanding officer said that he could not pursue the matter, that there was no machinery by which he could detain an apparent German civilian.

I returned to the courtyard, reported the decision. The Polish survivors looked at me in disbelief. Their outrage was contagious, and by now needed no translation. Our soldiers gathered around them, nodding in agreement. In a little while the German strode out of the manor house and began to cross the courtyard. The two Polish survivors moved to the side of the mess truck where tools were carried. One pulled the shovel from its holder, the other the pickax. They stood in the middle of the courtyard, facing the man they identified as the concentration-camp commandant. By now there were some 30 or so soldiers in the courtyard. I was the only officer. The soldiers barred the exit and formed a circle around the alleged SS commandant.

The Polish men began to swing their bludgeons. The German, who apparently had not sensed what was going on, was surprised, put up his arms to fend off the blows. He did not scream. He tried to run, but there was nowhere to go. The shovel and the pickax struck him again and again as fast as the semi-starved survivors could swing them. They caught his legs, and he went down.

I thought to myself, "I am being party to a barbaric act and putting myself in the position of the Nazis. Everyone is entitled to a fair trial. Am I not obligated by the code of civilization that I respect to step in and stop this?"

But I did nothing. I don't know that I could have stopped the frenzy. I told myself that, in excuse.

From some hidden reservoir of energy the young Poles struck the fallen body again and again. They split his skull. He moaned but he did not die. They swung and swung until they could swing no more. But he did not die. Utterly exhausted, the Poles could no longer lift their tools. They let the shovel and pickax drop to the ground and fell to their knees, panting for breath.

There was a moment of silence emphasizing uncertainty. But only a moment. Then a sergeant swung the carbine from his shoulder and put a bullet through the head of the hapless alleged commandant.

Ed. Note: Kenneth Zierler, M.D., is a professor of medicine and physiology at The Johns Hopkins University School of Medicine. The above article was originally printed in the *Sun*, April 18, 1995. *Reprinted with permission.* ■

In Korea, Then Home

Capt. Joseph M. Miller, M.C.



Ward scene in Pusan.

Following V-J day, I and the other members the 401st Medical Thoracic Surgical Detachment were sent from Okinawa to Korea, near Seoul. We were to provide medical support for a detachment that was sent to Quelpart Island (Cheju-do) off the southern coast of Okinawa in the early part of autumn to accept the surrender of the Japanese troops stationed there. We went on a Landing Ship, Tanks, and ran into a typhoon. I have never seen such wind and rain, which lasted the better part of two days.

After about nine months, with some time being spent at a station hospital in Pusan and the rest at a general hospital in Seoul, I was released to get transpor-

tation and go home. We disembarked at Seattle on May 30, 1946, and we were glad to get to the United States.

That night, five of us went to dinner at the Brown Palace Hotel. After the meal, we found that Joe E. Brown, the well-known comedian, was appearing in "Elmer." At the box office, we were told that the orchestra seats, which we could afford, we sold out. Looking at the motley group of men dressed in overseas woolens at the beginning of summer, the manager generously sold us a loge for the price of the orchestra seats. We enjoyed Mr. Brown tremendously, and he took numerous curtain calls. On the last curtain call, he saw us in the loge. He spoke of our contribution to the war effort, asked us to stand up, and then requested the audience to give us a standing ovation. Indeed, Joe E. Brown was a very gracious man.



Operating room in Pusan.

I was discharged as a major and immediately taken up into the Reserve Corps in the same rank. I remained in that capacity for about seven years until the advent of our children led to my resignation from the unit.

I sincerely hope the United States never undergoes such an experience again. I would not have missed the opportunity to serve, although the loss of life in the Pacific and elsewhere was tremendous. To those who now maintain that the United States should not have used the atomic bomb, I can lend only a partially sympathetic ear. The fact that the Pacific forces would have had a great number of casualties in an invasion of Japan is sometimes forgotten 50 year later. I am truly sorry that so many Japanese civilians were killed, but then I remember that perhaps only because that bomb was used, I and thousands of others were able to come home to enjoy the good thing which only the United States could offer. ■

A Year in the Cavalry

Pvt. Roland T. Smoot

I was drafted into the Army on September 24, 1945, after having completed four quarters in undergraduate school at Howard University in Washington, D.C. I was inducted at Fort Meade in Maryland, where I stayed for approximately one week. Then, I was sent to Fort McClellan in Alabama for basic training. As part of a small black squad, I received training that emphasized communication skills such as climbing poles and stringing telegraph wires. It appeared that the men in the squad were being prepared for the Signal Corps. In December, I was interviewed along with other men in my company regarding transfer to the Cavalry Detachment at West Point by officers of our unit.

In January 1946, I and a number of men in our unit were sent to West Point in New York as replacements for the servicemen who had been discharged from the Cavalry Detachment. This unit was responsible for taking care of the horses and the Army mascot (a mule). The horses were used for training the cadets to ride, in polo games, and for recreational use by officers of the base.

During my tour of duty at West Point, I was also a member of the basketball, softball, and track teams.

In November 1946, all draftees who had entered the armed services were ordered to be processed for dischage as soon as possible. An officer in my unit informed me that if I would re-enlist for a year, he would promote me to private, first class. I told him I would not accept if he offered to make me a general. I was officially discharged on December 9, 1946.

Ed. Note: Roland T. Smoot, M.D., practices internal medicine in Baltimore. He was president of the Baltimore City Medical Society in 1978, and president of Med Chi in 1983. ■

Lt. Col. Theodore E. Woodward, M.C.

In the Philippines, Lt. Woodward and his associate C.P. Philip identified the scrub typhus (tsutsugamushi fever) organism and its mite vector for the first time. The disease had continued to be a serious problem in Southeast Asia.

Soon after the war, Parke-Davis scientists developed Chloromycetin (chloramphenicol) after study of about 20,000 molds. They noted that this new antibiotic might inhibit the *Rickettsia tsutsugamushi.* Joseph Smodel made the initial key studies. Armed with about two pounds of the drug—then the entire world's supply—Dr. Smodel, head of the Walter Reed Scrub Typhus Mission, chose Dr. Woodward, another physician entomologist, and scientists as a team. They flew to Malaya to test the efficacy and safety of the new medication. Soon after their arrival at the Institute for Medical Research in Kuala Lumpur, they were taken to evaluate a man with the classic findings of scrub typhus. He had an eschar where a mite had bitten him. Within 24 hours of initiation of treatment with Chloromycetin, the patient was fully recovered and asking to be released. During the next several months, another 30 patients with confirmed scrub typhus recovered after being given the drug.

After the war, Dr. Woodward scored another first while in Malaya

"One of the most dramatic diseases encountered in SWPA [Southwest Pacific Area] was scrub typhus {tsutsugamushi fever}. . . . At the time [an outbreak in New Guinea occurred in the summer of 1944], treatment was symptomatic, and the precise pathological lesions and deranged physiological functions were not known or understood. Later, as post mortem material was collected and it became evident that the widespread involvement of the capillary blood vessels produced lesions in all organs of the body, the signs and symptoms were more understandable. Early in the experience with this disease, patients were seen to die from heart failure or from shock, with varying degrees of cyanosis and of moisture in the lungs. . ."

"Preparations [for the arrival of the group sent from the United States of America Typhus Commission to New Guinea] included the setting up of laboratories . . . in conjunction with a station hospital in an . . . area in which scrub typhus had been prevalent. Here the disease was studied, the location and transmission of the mites were determined, new forms of mites were described, and finally, methods for the prevention of typhus were elaborated and clearly described . . ."

"Patients recovering from scrub typhus were found to present a real problem in rehabilitation. The disease had acquired a fearsome reputation, and convalescent patients, as well as many medical officers, were frequently convinced that they had suffered some permanent damage to the heart or other vital organs . . ."

"Reassurance may be soundly based on the careful studies carried out in this area on large series of convalescent patients in whom the physical signs, the X-ray findings, the electrocardiograms, the vital capacities, and the exercise tolerance tests were

continued on next page

when he cured a case of typhoid fever with Chloromycetin—the first known cure for the disease. During his infectious disease studies activity in the South Pacific, he worked in New Guinea, Leyte, Luzon, and Manila.

"The occurrence of murine typhus in the Philippine Islands had been questionable, although DeRoda had reported its probable occurrence in 1937. Its presence in Manila and on Mindanao was definitely proved by Woodward, Philip, and Loranger in 1945" [Woodward TE, Philip CB, Loranger GL. Endemic typhus in Manila, P.I. Report of cases and identification of the murine rickettsial agent in domestiv rats by complement fixation. J Infect Dis *1946;78:167-172].*

From: Coates JB Jr, Hoff EC, Hoff PM, eds. *Medical Department, United States Army. Preventive Medicine in World War II. Communicable Diseases. Arthropodborne Diseases Other Than Malaria.* Vol. II. Washington, DC: Office of the Surgeon General, Department of the Army; 1964:272.

critically evaluated to determine the frequency of residual cardiovascular damage. The results of these studies indicated that there is no evidence of permanent organic damage and that functional neurocirculatory symptoms were no more frequent than they are after other severe febrile illnesses. It may be concluded that, though vascular and perivascular lesions occur in the heart as well as in the lungs, brain, and other tissues during the active stage of the disease, the recovery from these inflammatory processes is complete, with very occasional exceptions. When permanent disability persists, as it does in these very occasional cases, it takes the form of varying degrees of deafness, diminished vision, involvement of the peripheral nerves, or other residual damage, chiefly of the nervous system."

From: Thomas HM Jr. Southeast Pacific Area. In: Coates JB Jr. Havens WP Jr, eds. *Medical Department, United States Army. Internal Medicine in World War II. Activities of Medical Consultants.* Vol. 1. Washington, DC: Office of the Surgeon General, Department of the Army; 1961:524-525, 531.

The value of the new antibiotic was further documented in Malaya in 1948, when 48 male volunteers at a rubber plantation surrounded by jungle were exposed to scrub typhus-carrying mites for 8 hours a day over 10 hot days. The team documented that each man had an average of 15 mites attached to him daily. Half were then given Chloromycetin and half, placebo. When those given placebo developed scrub typhus, they were given Chloromycetin. All recovered. The same year, Dr. Maurice Pincoffs and Dr. Woodward treated Rocky Mountain spotted fever patients in Maryland with Chloromycetin with the same successful result. The Malayan studies under Dr. Smodel earned a nomination for the Nobel Prize.

Now retired after 27 years as chairman of the department of medicine at the University of Maryland School of Medicine, Dr. Woodward is still actively involved in research, teaching medical students, and caring for patients.

MARION FRIEDMAN, M.D.

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Operation Crossroads

Capt. Samuel R. Pines, M.C.

Fifty years have passed since the birth of the atomic bomb. Its remembrance is usually associated with the unlimited destructive power of the scientific weapon and neglects the secondary, positive uses of the chemistry of radiation—the unlimited source of nonmilitary power, advances in medical care, and the many other applications of radiation. But, let us focus on the genesis of this new era.

Alamagordo. What was that? Or Where? Only after the two atomic bombs had been dropped on Hiroshima and Nagasaki did I learn of the test of bomb number 1 at Alamagordo, New Mexico, which originally was labeled an explosion of faulty, outdated TNT. In fact, it was a test to determine the possible usefulness of a bomb created through four years of secret scientific debate, chemical and physical investigation, and the arrival of moral and ethical decisions concerning its destructive power.

As an Army physician attached to the Manhattan District Engineers (the wartime name for the atomic bomb project) at Oak Ridge, Tennessee, I received a call from the commanding officer with an unusual request. Could I get together with the base veterinarian, pick up some necessary instruments, a Jeep with driver, and try to locate a dead cow that had been part of a herd in a restricted field, in order to perform an autopsy? I was instructed that all findings would be restricted information.

After finally locating the herd and the hapless cow, I noticed that the backs of all the animals were hairless or had a gray stubble, due to the radioactive fallout from the earlier use of the bomb at Alamagordo. The herd had been secretly relocated to Oak Ridge for observation. This was my first personal inkling of the connection between the Oak Ridge complex, the Manhattan District Engineers, and the bombing of the two Japanese cities. Secrecy was so efficient that except for a very few top officials, no one who worked at the base knew or understood the mission of the Manhattan District Engineers.

After the awesome destructive power of the three bombs (Hiroshima, Nagasaki, Alamagordo) became public, the U.S. Navy and the navies of nations around the world were very concerned about protecting their fleets, especially after the sneak

attack on Pearl Harbor in 1941. The three previous explosions had been air bursts, so a sea environment test explosion could be very informative. Thus the tests code-named Operation Crossroads were initiated. Bikini Island in the Pacific Ocean was selected, the natives were induced to resettle, and a major target armada was assembled in the lagoon.

The Manhattan Project issued a call for volunteers to participate in the test. I enlisted as a curious adventurer. I had no inkling of the surprises and experiences awaiting me, nor did the other volunteers.

A group of us was assigned to the U.S.S. *Haven*, a hospital ship, which departed from San Francisco on May 29, 1946, carrying radiological technicians, naval engineers, salvage experts, damage controllers, physicians for radiation safety procedures, and a host of other specialists, all headed by Col. Stafford C. Warren. En route to Bikini, we had daily lectures, discussions, and frequent conjectures of what to expect. We arrived June 12, 1946. What a sight!

The lagoon of the Bikini Atoll was roughly oval, measuring about 25 by 10 miles, filled with about 100 to 200 anchored ships of every description representing many different nations (e.g., Germany, Japan, the United States). After more briefings, distribution of protective clothing, gear, instrumentation, and a host of instructions, we anxiously awaited Monday, July 1, Able Day, the nickname for the air drop. The U.S. Navy battleship *Nevada* was in the center of the target area.

The *Haven* had left the lagoon on the previous day and cruised to a distance of about 20 miles when the bomb drop was made at 0900. Wearing heavy shielding goggles, I faced away from the target blast and then slowly and cautiously turned toward the site of the explosion. I saw a large fireball, then a large stalk and cap of a mushroom were formed. The cloud—mixed with large chunks of burning metal, debris, and vapor—rose about 10,000 feet. Arrayed in many colors, it was a breathtaking display of power and destruction. The cloud rose to high altitudes and stayed intact for several minutes before dispersing in the sky. I did not feel the heat wave for at least 30 minutes after the flash, but then it was unmistakable. The destruction before our eyes was enormous. A number of the target ships were sunk, sinking, or burning, and much of the superstructure of the vessels was destroyed. The drone planes and boats recorded such high radiation levels that entrance back into the lagoon was forbidden for 24 hours.

On the following day, as the radiological safety officer with the boarding team, I noted that many of the target ships were still highly radioactive although structurally intact. After boarding and inspecting about four or five ships, we returned to give our report. During the next few days after the Able air burst, a few more ships sank and underwater divers confirmed that damage to the fleet was considerable.

Phase two of the operation involved an underwater test explosion held about three weeks after the Able detonation and after sufficient data had been obtained from the animals and equipment on board the target vessels. The planned underwater explosion, code-named Baker, was conducted on Thursday, July 25. I was aboard a salvage tug, the *Clamp*, when the explosion occurred at 0835. We were about ten miles away and the visibility was excellent.

We saw an immense pressure wave, like a large white cloud, arise from the water, extend about four miles in diameter, and attain 500 to 1,000 feet in height. It covered all of the vessels in the lagoon. In the middle of the cloud of water, a central column of steam and water rose to about 10,000 feet. The color of the column was dark gray-brown and it contained large, black, smoking pieces of debris. Two or three large ships were thrust up from the sea for about 50 to 1000 feet by the force of the blast. This material then fell back into the water. We felt and heard a large blast about 12 seconds after the explosion. The volume of water and cloud of steam remained for about 20 minutes and then disappeared in the sky.

About 1100, after the surveys of the remote-controlled drone boats were monitored, the *Clamp* was the first salvage ship to return to the lagoon. Our boarding party then became actively involved in inspection and survey procedures. Many ships had escaped damage to their superstructures, but the underwater hulls were cracked, producing slow sinking. Radioactive fallout was so great on most target vessels that it was difficult to put special crews aboard for salvage. Thus, many ships were sunk at their moorings.

In addition, because the water of the lagoon maintained high levels of radioactive fallout, many observer ships became contaminated. Later, efforts were made to cleanse the radiation particles by using high pressure steam hosing with sea water and special additive compounds, but only minimum improvement resulted. Many service personnel did not fully comprehend or appreciated the hazards of the exercise and were thoroughly contaminated with radiation particles. A potential disaster became a very serious medical nightmare. Morale was low, as it was impossible to identify the physical enemy except by reading Geiger counters. Contaminated clothing and shoes were discarded, and many of the ships were steamed to the open seas to be hosed down. Water tanks and pipes were cleaned and fresh water made.

Many high-level personnel conferences were held and shortly thereafter many of the boarding teams were ordered to return to the United States. I was included in one of these groups.

I had volunteered for an adventure. I experienced one that I will never forget.

Ed. note: Dr. Pines practiced general surgery in Baltimore until his retirement. He lives in Baltimore. ■

For what availed it, all the noise

And outcry of the former men?—

Say, have their sons achieved more joys,

Say, is life lighter now than then?

The sufferers died, they left their pain—

The pangs which tortured them remain.

MATTHEW ARNOLD

"Stanzas from the Grande Chartreuse"

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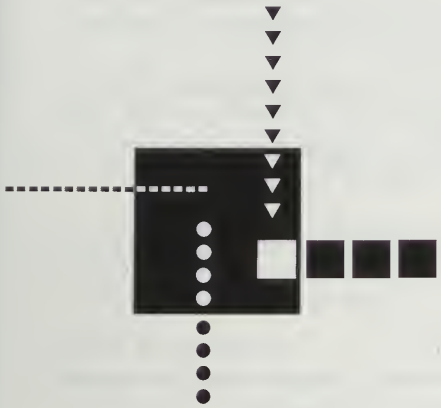
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Organized Medical Staff Section



Representation, Education and Networking

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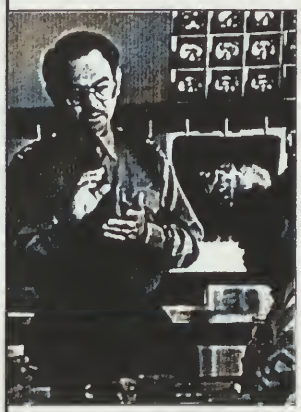
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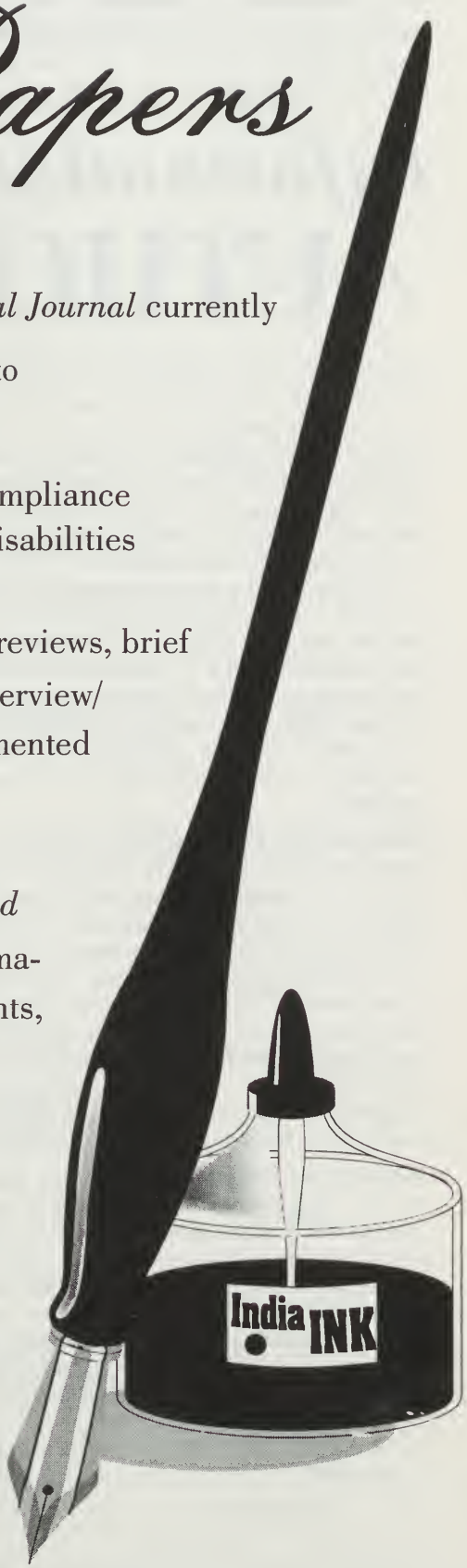
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  1. Stevens MB. The clinical spectrum of SLE. Md Med J 1991; 10:875–85.
  2. Ropes MW. Characteristics, manifestations, and pathologic findings. In: Ropes MD, ed. Systemic Lupus Erythematosus. Cambridge, MA: Harvard University Press. 1976; 50–4.

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Topics in ambulatory medicine VII, at the Stouffer Renaissance Harborplace Hotel, Baltimore, MD. 18 Cat 1 AMA/AAFP credits. Fee: $500/physicians; $300/residents, fellows, allied health professionals.	**Nov. 15–17**
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University of Maryland School of Medicine

For each course, additional information may be obtained by contacting the Program of Continuing Education, University of Maryland School of Medicine, Room 14-011, BRB, 655 W. Baltimore St., Baltimore, MD 21201 (410-706-3956) or by calling the phone number listed after a specific program. FAX 410-706-3103.

Treatment in epilepsy/Epilepsy Association of Maryland, at the Holiday Inn, Frederick, MD. 5 Cat 1 AMA credits. Fee: $50. Info: Cathy Bowers, 410-828-7700. **Nov. 3**

Women's psychological issues across the lifespan: health, heredity, hormones, hype, at the Omni Inner Harbor Hotel, Baltimore, MD. 6.5 Cat 1 AMA credits. Fee: $100. Info: Roxanne Zaghab or Donna Willis, 410-828-1737. **Nov. 3**

Endocrinology and metabolism update for the practicing physician—1995, at the Pier 5 Clarion Inn, Baltimore, MD. 10 Cat 1 AMA credits. Fee: $185. Info: John Wilber, M.D., Connie Ball, 410-328-2515. **Nov. 3–4**

Cyrus L. Blanchard and Bernard S. Kleiman lectures on head and neck trauma, at the University of Maryland Medical School teaching facility, Baltimore, MD. 8 Cat 1 AMA credits. Fee: $100. Info: Charles M. Suter, Ph.D. **Nov. 10–11**

Pollin Fellowship conference: crisis counseling for patients and families with chronic medical illnesses, at the Radisson Lord Baltimore, Baltimore, MD. 6 Cat 1 AMA credits. Fee: $45. Info: Vertell Porter-Brown, 410-328-6735 or Sharon M. Stenhouse, 410-706-3958. **Nov. 17**

University of Maryland School of Medicine (continued)

Surgical dilemmas in glaucoma management, at the Sheraton Inner Harbor Hotel, Baltimore, MD. 7 Cat 1 AMA credits.

Self-Directed CME Activities

Optimal dosing in chemotherapy: adoptive control with carboplatin, video tape, monograph and test. Expires March 1996, 3 Cat 1 AMA credits. Info: 212-924-3044.

U.S. medical costs and values: primary prevention versus end stage treatment, monograph and test. Expires Aug. 1996, 2 Cat 2 AMA credits. Info: 908-281-3772.

Lipid management for coronary heart disease: a proven hypothesis, audio tape and test. Expires Aug. 1996. 1 Cat 2 AMA credit. Info: 609-497-9743.

Drug-drug interaction: focus on antidepressants, monograph w/response test. Expires Aug. 30, 1996. 2 Cat 1 AMA credits. Info: 203-629-2555.

Continuously throughout the year

Academic rounds and conference, each academic department within the school of medicine has a series of lectures and/or seminars available to physicians. Cat 1 AMA credits available. Info: 410-706-3956.

Miscellaneous meetings

Pediatric ophthalmology: an update for pediatricians and family practitioners, at the GBMC Conference Center, Baltimore, MD. 4 Cat 1 AMA credits. Info: Ann Harris, 410-828-3670. **Nov. 4**

St. Joseph Medical Center annual symposium: The interface of medicine and psychiatry, at the Noppenberger Auditorium, St. Joseph Medical Center, Towson, MD. 6 Cat 1 AMA/PRA/AAFP credits. Fee: $45/physicians; $45/psychologists; $25/house staff, nurses, allied health professionals. Registration deadline: Oct. 27. Info: Pat Fuchsluger, 410-337-1501. **Nov. 4** **Oct. 14**

Oncology issues for primary care physicians, sponsored by the Maryland Academy of Family Physicians at the Columbia Inn, Columbia, MD. 6.75 Cat 1 AMA/AAFP credits. Fee: $55/members; $75/non-members; $35/allied health professionals. No fee for inactive/life members/residents/medical students. Info: Maria E. Delgado, M.D., 410-747-1980. **Nov. 11**

Topics in clinical rheumatology: The Mary Betty Stevens, M.D., arthritis update for family practitioners, internists, orthopedists, rheumatologists, and other primary care providers, sponsored by the Arthritis Foundation, Maryland Chapter, at the Sheraton Baltimore North, Towson, MD. Fee: $50. Info: J. Karen Krug, 410-602-0160. **Nov. 14**

Twelfth annual clinical update in pulmonary medicine CME course and luncheon, at the Trump Regency Hotel, Atlantic City, NJ, sponsored by the department of pulmonary medicine, Deborah Heart and Lung Center. CME TBA. Info: 201-385-8080. **Nov. 19**

Williamsburg conference on heart disease, sponsored by the American College of Cardiology in Williamsburg, VA. 18.5 Cat 1 AMA credits. Info: 800-257-4739. **Dec. 3–6**

Modern approaches to office emergencies, sponsored by the Maryland Academy of Family Physicians, Annapolis Waterfront Hotel, Annapolis, MD. 10 Cat 1 AMA/AAFP credits. Fee: $115/members; $150/non-members; $65/allied health professionals. No fee for inactive/life members/residents/medical students. Info: Maria E. Delgado, M.D., 410-747-1980. **Feb. 3–4**

Miscellaneous meetings (continued)

48th Annual meeting, scientific session & exposition, sponsored by the Maryland Academy of Family Physicians, Sheraton Fontainebleau Hotel, Ocean City, MD. 26.5 Cat 1 AMA/ AAFP credits. Fee: $280/members; $325/non-members; $110/allied health professionals. Info: Leonard H. Raucher, M.D., 410-747-1980. — **May 16–19**

Continuously throughout the year

American College of Cardiology, The Heart House Learning Center, Bethesda, MD. Info: 1-800-257-4737.

Cardiac auscultation for physician assistants, nurse practitioners and cardiac nurses.	**Nov. 29–Dec. 1**
Advanced echocardiography: Case studies and concepts.	**Dec. 11–13**
Problem solving in interventional cardiology.	**Jan. 8–10**
Interventional echocardiography: transesophageal, exercise, pharmacologic, and intravascular—emphasizing case studies.	**Jan. 18–20**
Congenital heart disease in adolescents and adults.	**Jan. 22–24**
Advanced echocardiography: illustrative case studies and latest techniques.	**Feb. 5–7**
Molecular biology for the cardiologist.	**Feb. 21–23**
Advanced clinical cardiac electrophysiology.	**Feb. 26–28**
Cardiovascular surgery: challenging management problems in coronary artery disease, valvular heart disease, and thoracic aortic pathology.	**Feb. 26–Mar. 2**
Echocardiography for sonographers and cardiology trainees: 2-D/Doppler, color flow imaging, TEE, and stress echo— practical review.	**Mar. 7–9**
Echocardiography in coronary artery disease: live demonstation and interpretations of exercise and pharmocolgic stress echo.	**April 10–12**
Advanced pediatric cardiac ultrasound.	**April 15–17**
Cardiac pacing—1996: new indications for pacing, rate adaptive pacing updates, update on cardioversion–defibrillation.	**April 18–20**
Transesophageal echocardiography: live demonstation of technique, image orientation, interpretations, and current and evolving applications of biplane and multiplane TEE.	**April 24–26**
Echocardiography as we approach the year 2000—teleconference.	**April 27**

Fluorescein angiography conference, sponsored by the Retina Center of Maryland, Baltimore, MD. First and third Mondays of each month; 8:00–9:00 am. Fee: none. Info: C. Love, 410-337-4500.

Sinai Hospital of Baltimore medical grand rounds, Zamoiski Auditorium, Thursdays, 9:00 - 10:00 a.m. Info: 410-578-5528.

Diabetic retinopathy	**Nov. 9**
AIDS: the state of the syndrome	**Nov. 16**
Acute myocardial infarction	**Nov. 30**
The renin-angiotensin system	**Dec. 7**

Miscellaneous meetings (continued)

Community-acquired pneumonias	**Dec. 14**
Medical interviewing and the doctor-patient relationship in the managed care era	**Dec. 21**

St. Joseph Medical Center Minimally Invasive Training Institute. Surgical training seminars in Towson, MD. Seminar fees: $750/spine; $600/others. Course fees: $2,250/spine; $600/others. Info: Colleen Galloway, 410-337-4843.

General Surgery

Technology program (colon, gastric, hernia), 8 Cat 1 AMA credits.	**Nov. 3**
Laparoscopic gastric surgery course, 6 Cat 1 AMA credits.	**Nov. 4**
Laparoscopic gastric seminar, 6 Cat 1 AMA credits.	**Nov. 8**
Laparoscopic hernia seminar, 6 Cat 1 AMA credits.	**Nov. 20**

Gynecologic procedures

Hysteroscopy course, 8 Cat 1 AMA credits.	**Dec. 1**
Laparoscopic bladder neck suspension course (BURCH procedure), 8 Cat 1 AMA credits.	**Dec. 2**

Orthopedic surgery

Endoscopic spinal surgery course, 16 Cat 1 AMA credits.	**Nov. 10–11**
Laparoscopic or thoracoscopic spinal seminar, 7 Cat 1 AMA credits.	**Dec. 4**

PHYSICIAN'S RECOGNITION AWARD

During August 1995, the physicians listed below received the American Medical Association (AMA) Physician's Recognition Award. Established in 1968, the award's purpose is to encourage physician participation in continuing medical education and to recognize those physicians who have voluntarily completed programs of continuing medical education.

James Brown
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Paul A. De Vore
Kirk D. Denicoff
Allen C. Egloff
Roger H. Halterman
Thomas G. Johnson
Robert B. Kroopnick
Ann E. Lewandowski
Angelo J. Lucco
Joseph T. Michaels
Julio C. Novoa
Barry Rosenberg
Paul A. Rusonis
Janelle L. Sandford
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201 West Preston Street, Baltimore, Maryland 21201 (410) 225-6700

November, 1995
Prevention and Control of Influenza

The following table of recommended dosages of amantadine and rimantadine has been extracted from "Prevention and Control of Influenza: Recommendations of the Advisory Committee on Immunization Practices (ACIP)", MMWR 44:RR-3, April 21, 1995. The entire document is available on the Internet at http://www.crawford.com/cdc/mmwr/mmwr.html or by contacting the Center for Immunization at (410) 225-6679. The following three pages contain the CDC's Vaccine Information Statement (VIS) for the 1995-96 influenza vaccine and is intended to provide information to the vaccine recipient (or parent or guardian). Please reproduce these for use in your office or contact the Center for Immunization for additional copies.

Recommended dosage for amantadine and rimantadine treatment and prophylaxis

	Age			
Antiviral Agent	**1-9 yrs**	**10-13 yrs**	**14-64 yrs**	**≥65 yrs**
Amantadine*				
Treatment	5 mg/kg/day up to 150 mg† in two divided doses	100 mg twice daily§	100 mg twice daily	≤100 mg/day
Prophylaxis	5 mg/kg/day up to 150 mg† in two divided doses	100 mg twice daily§	100 mg twice daily	≤100 mg/day
Rimantadine¶				
Treatment	NA	NA	100 mg twice daily	100 or 200** mg/day
Prophylaxis	5 mg/kg/day up to 150 mg† in two divided doses	100 mg twice daily§	100 mg twice daily	100 or 200** mg/day

Note: Amantadine manufacturers include: Dupont Pharma (Symmetrel®-syrup); Solvay Pharmaceuticals (Symadine™-capsule); Chase Pharmaceuticals and Invamed (Amantadine HCL-capsule); and Copley Pharmaceuticals, Barre National, and Mikart (Amantadine HCL-syrup). Rimantadine is manufactured by Forest Laboratories (Flumandine®-tablet and syrup).

*The drug package insert should be consulted for dosage recommendations for administering amantadine to persons with creatinine clearance ≤50 mL/min.

†5 mg/kg of amantadine or rimantadine syrup = 1 tsp/22 lbs.

§Children ≥10 years of age who weigh <40 kg should be administered amantadine or rimantadine at a dose of 5 mg/kg/day.

¶A reduction in dose to 100 mg/day of rimantadine is recommended for persons who have severe hepatic dysfunction or those with creatinine clearance ≤10 mL/min. Other persons with less severe hepatic or renal dysfunction taking >100 mg/day of rimantadine should be observed closely, and the dosage should be reduced or the drug discontinued, if necessary.

**Elderly nursing-home residents should be administered only 100 mg/day of rimantadine. A reduction in dose to 100 mg/day should be considered for all persons ≥65 years of age if they experience possible side effects when taking 200 mg/day.

NA=Not Applicable.

INFLUENZA VACCINE

What you need to know before you or your child gets the vaccine



ABOUT THE DISEASE

Influenza (sometimes called the flu) is a serious disease. Here are a few important facts:

1. It spreads when influenza viruses pass from an infected person to the nose or throat of others.

2. Influenza can cause:
   - fever
   - chills
   - headache
   - cough
   - sore throat
   - muscle aches

3. It can lead to pneumonia and death.

4. Influenza can make people of any age ill. Although most people are ill for only a few days, some have a much more serious illness and may need to be hospitalized. Thousands of people die each year from influenza-related illnesses. Most deaths caused by influenza are in elderly people.

ABOUT THE VACCINE

Who should get influenza vaccine?

Group #1. People who are at risk for getting a serious case of influenza or a complication should get the vaccine. This includes:

- ☞ All people 65 years of age or older
- ☞ Residents of long term care facilities housing persons of any age with chronic medical conditions
- ☞ Any child or adult, including pregnant women, who has a serious long-term health problem with:
  - heart disease
  - lung disease
  - anemia
  - kidney disease
  - metabolic disease, such as diabetes
  - asthma

  AND in the past year had to:
  - see a doctor regularly, or
  - be admitted to a hospital

- ☞ People who are less able to fight infections because of:
  - a disease she/he was born with
  - infection with Human Immunodeficiency Virus (HIV), the virus that causes AIDS

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION
U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Centers for Disease Control
and Prevention

- treatment with drugs such as long-term steroids
- cancer treatment with x-rays or drugs

☞ Children and teenagers 6 months to 18 years of age on long-term aspirin treatment, who, if they catch influenza, could develop Reye syndrome which causes coma, liver damage, and death.

Group #2. Anyone who has close contact with people who are at risk for getting a serious case of influenza. This includes:

☞ People—including children—who live with persons in high risk groups (group 1 above)

☞ Health care workers (doctors, nurses, hospital and medical office staff)

☞ Personnel of nursing homes or chronic care facilities

☞ People who provide home-care to high-risk persons, such as visiting nurses and volunteers.

Group #3. In addition, an influenza shot may be given to:

☞ Persons who provide important community services

☞ People in schools and colleges if outbreaks would cause a major upset in the school activities

☞ Pregnant women who are more than 6 months pregnant or who have just delivered during the influenza season

☞ People going to the tropics any time of year or to countries south of the equator between April-September

☞ Anyone who wants to reduce their chance of catching influenza.

When should you get influenza vaccine?

The viruses that cause influenza change often, so people who need the vaccine should get it every year.

The vaccine begins to protect you after 1 to 2 weeks and protection may last up to one year. Influenza is most common in the U.S. from December to April, so it is best to get the vaccine in the fall. People 9 years and older need one shot each influenza season, while children less than 9 years may need a second shot after one month.

Will the vaccine keep you from getting the influenza this year?

Since influenza viruses change frequently, they may not always be covered by the vaccine. Also, other viruses cause diseases that seem like the influenza and the influenza vaccine does not protect against these other viral infections.

The vaccine contains viruses that are the same or similar to those thought to be most likely to come to the U.S. this year. Their names are:

A/Texas/36/91 (H1N1)
A/Johannesburg/33/94 (H3N2)
B/Harbin/07/94

All the viruses in the vaccine are killed so you cannot get influenza from the vaccine.

Can other vaccines be given at the same visit?

Yes, but in a different limb. These include:
- Pneumococcal vaccine
- All childhood vaccines

Because influenza vaccine may cause fever, children 15 months old or older who are getting influenza vaccine with a pertussis (whooping cough) vaccine, should get an acellular pertussis (DTaP) vaccine.

What are the risks from influenza vaccine?

As with any medicine, there are very small risks that serious problems, even death, could occur after taking the vaccine. The risks from the vaccine are **much smaller** than the risks from the disease if people stopped using vaccine. Almost all people who get influenza vaccine have no serious problems from it.

Children less than 13 years old should be given only split virus vaccine to reduce chances of side effects. Split-virus vaccines can also be used by adults.

If mild or moderate problems occur, they usually start soon after the vaccination and usually last up to 1-2 days:

- soreness, redness, or swelling where the shot was given
- fever
- aches

Unlike the 1976 swine influenza vaccine, recent influenza shots have not been clearly linked to a paralytic illness called Guillain-Barre Syndrome (GBS), from which people usually recover. In 1990-91 and 1993-94 there may have been a small chance that getting GBS was linked to influenza vaccine in people 18 to 64 years old, but not in people older than 64. The chance of GBS after influenza vaccine is far less than the chance of getting severe influenza that could be prevented by the vaccine.

Tell your doctor or nurse if you:

- have a serious allergy to eggs
- ever had a serious allergic reaction or other problem after getting influenza vaccination
- were ever paralyzed by Guillain-Barre Syndrome
- are pregnant or think you might be pregnant
- now have a moderate or severe illness.

What to do if there is a serious reaction

→ Call a doctor or get the person to a doctor right away.

→ Write down what happened and the date and time it happened.

→ Ask your doctor, nurse, or health department to file a Vaccine Adverse Event Report form or call: (800) 822-7967 (toll-free)

How to learn more

If you want to learn more, ask your doctor or nurse. She/he can give you the vaccine package insert or suggest other sources of information.

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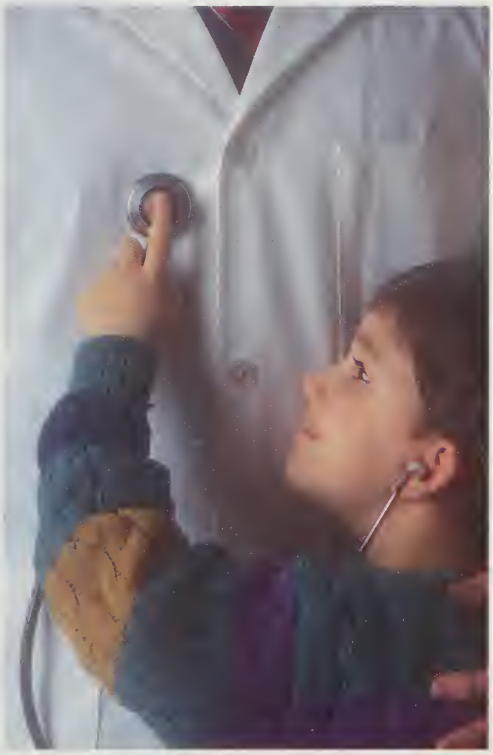
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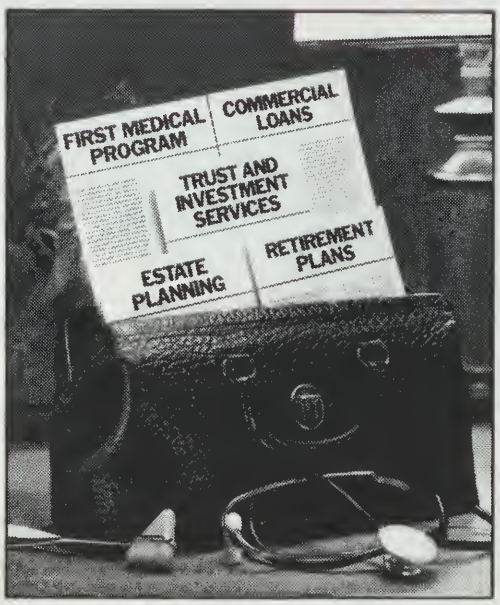
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But you can help combat the tobacco industry's efforts to addict young people.

The FDA is proposing to reduce access to and limit the appeal of tobacco products to children by:

- requiring age verification for the purchase of any tobacco product
- eliminating mail order sales, vending machines, free samples, self-service displays and the sale of single cigarettes or packages with fewer than 20 cigarettes
- banning outdoor advertising within 1,000 feet of schools and playgrounds
- permitting only black and white advertising for billboards, bus signs, and print ads in publications with significant youth readership
- prohibiting sale or giveaway products such as caps or gym bags that carry tobacco product brand names or logos
- prohibiting brand name sponsorship of sporting or entertainment events
- requiring the tobacco industry to fund a public education campaign for children

What can you do?

Write the FDA at Docket No. 95N-0253, Food and Drug Administration, Room 1-23, 12420 Parklawn Dr., Rockville, Maryland 20857, and express support for this FDA proposal. Letters or cards must be postmarked by **January 2, 1996**.

Contact your federal representatives and tell them you support this proposal. For the name and address of your federal representatives, call the Tobacco Control Clearinghouse at Med Chi, 410-539-0872 or 1-800-492-1056.

Urge your patients to write to the FDA and their representatives.

Free pre-printed mailing cards supporting this proposal are available through the Tobacco Control Clearinghouse at Med Chi. Call 410-539-0872 or 1-800-492-1056 to obtain a supply of cards which can be used by you and your patients.

Chief Executive Officer's Newsletter

December 1995

Thomas Allen, M.D., Elected Med Chi Treasurer

Thomas E. Allen, M.D., trustee from Baltimore County, has been elected by the Board of Trustees as Med Chi's treasurer. Dr. Allen replaces Carol W. Garvey, M.D., who resigned from the Board to accept the position of Montgomery County Health Officer.

AMA Initiatives for Medicare Reform

The AMA has set the following as its top priorities for Medicare reform:

- antitrust relief;
- changes in the physician update formula;
- professional liability reform including a $250,000 cap on noneconomic damages;
- patient protection provisions, including fairness rules for physician deselection cases;
- regulatory relief from CLIA and the physician self-referral rules; and
- inclusion of medical savings accounts as an option for beneficiaries.

HMOs Ordered to Pass Along Negotiated Discounts

New Hampshire's insurance department will require that HMOs pass on discounts negotiated with providers to consumers and calculate patient copayments based on the discounted rather than the retail price. Healthsource, New Hampshire's second largest HMO, recently began passing along discounts to subscribers, and Blue Cross Blue Shield agreed to begin passing on discounts under its point of service plan last spring.

In August, a federal court in Ohio ruled that Blue Cross and Blue Shield of Ohio misled policyholders by not disclosing price discounts negotiated with providers and that the company breached its fiduciary duties under the Employee Retirement Income Security Act (ERISA).

Provider Service Networks

Representatives of the insurance industry are voicing strong opposition to the special treatment provider service networks (PSN) would receive under either the House or Senate GOP Medicare bills. Under the House bill, PSNs defined as formal affiliations of health care providers could contract directly with the federal Medicare program, would be regulated at the federal level, and would have less strict solvency requirements. The House bill would allow PSNs to be exempt from state requirements such as state premium taxes and anti-managed care laws to which the HMOs are subject. (Source: BNA's *Health Care Policy*, Vol. 3, No. 39, Oct. 2, 1995)

The National Association of Insurance Commissioners is drafting model state laws and regulations to establish uniform quality and solvency standards for all health care entities bearing risk. These nonbinding laws and regulations are being proposed to help guide state policymakers.

Off-label Drug Use Panel Created

Secretary of Health Martin P. Wasserman, M.D., J.D., has recently appointed a panel of medical experts to review off-label drug uses. Individuals or providers who have a dispute with an insurer or HMO regarding payment for an off-label use of medication may appeal to the Maryland Insurance Administration. After an appeal has been filed, the insurance commissioner may ask for advice from the secretary of health and the panel of experts as to whether the proposed off-label drug use is warranted.

For more information, contact Randy Reichel, Associate Commissioner, Maryland Insurance Administration, at 410-333-4968.

Medicare Issues

Limiting Charge Clarification: For dates of service after December 31, 1994, regardless of which insurance company is the primary insurer for patients covered by Medicare, a nonparticipating physician can only bill the Medicare limiting charge. The Social Security Act Amendments of 1994 prohibit a nonparticipating provider who does not accept assignment from billing or collecting amounts above the applicable limiting charge.

Advance Notification: Advance notification alerts a beneficiary that Medicare is likely to deny payment for a particular service along with the reason why the physician believes payment will be denied. Physicians are protected from liability when they inform the beneficiary in advance that Medicare will probably not pay. The physician must then obtain the beneficiary's agreement to pay for the service. If advance notification is not given, and the service is denied, the physician may not charge the beneficiary.

Screening Pap smears which are performed more frequently than once every three years require advance notification to the beneficiary. Screening mammograms which are not performed in certified screening mammography centers, or which are performed more frequently than allowed by Medicare, also require advance notification.

Mammography Certification: All facilities performing the technical component of screening and diagnostic mammographies must be certified by the U.S. Food and Drug Administration to qualify for Medicare payment as required by the Mammography Quality Standards Act.

Medicare Secondary Payer Final Rule: On August 31, 1995, the Health Care Financing Administration (HFCA) issued its final rule for the Medicare Secondary Payer Program. The rule prohibits group health plans from offering different benefits to plan participants who are eligible for Medicare, whether eligibility is based on age, disability, or end-stage renal disease. Although the rule took effect on October 2, 1995, HFCA can cite plans for violation of the rule's benefit requirement as far back as January 1, 1987, for coverage of disabled individuals; December 20, 1989, for coverage pertaining to age or end-stage renal disease; and August 10, 1993, for failure to refund mistaken Medicare payments.

Influenza Virus Vaccination: HCFA is urging providers to offer the influenza virus vaccination to individuals enrolled in Medicare Part B. Part B reimburses for the flu vaccine and its administration at **100% of the Medi-**

care-allowed amount. The Part B deductible and coinsurance do not apply. For unassigned claims, the beneficiary's responsibility is the difference between the amount actually billed and the amount Medicare pays. For Medicare HMO members, Medicare will pay only when beneficiaries receive their flu shots at their HMO.

HCIA Study on Babies Delivered by C-section

A study by Baltimore-based HCIA found that babies delivered by C-section who are discharged within 24 hours of delivery are 3.3 times more likely to become sick enough to be readmitted to the hospital than babies who remained in the hospital for two or more days. The study also showed that 57.7% of all mothers with HMO coverage were discharged within 24 hours or less of delivery, while 35.9% of mothers with non-HMO coverage were discharged within 24 hours. (Source: *The Executive Report on Managed Care*, Sep. 1995)

Vermont's Section 1115 Medicaid Expansion

The federal government gave preliminary approval to Vermont's Section 1115 Medicaid demonstration waiver proposal that would allow the state to cover up to 15,000 people who are currently uninsured through expected savings from moving Medicaid recipients into managed care. (Source: *BNA's Health Law Reporter*, June 29, 1995.)

1996 CPTs and ICDs Available

The Med Chi library has copies of both 1996 CPT and the 1996 ICD available. The prices are:

CPT 1996 *(book only, soft bound)*

Member	$38.00
Nonmember	$48.00

ICD-9-CM *(St. Anthony's Compact Code Book for Physician Payment, v.1 & 2 in one volume (soft bound)*

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The library does not carry mini-books or any other versions of these items. All orders must be prepaid. These items can be picked up during business hours, or sent UPS. Please make checks or money orders payable to **Med Chi Library**. You can mail your order with payment to Med Chi Library, 1211 Cathedral Street, Baltimore, MD 21201, attn: Technical Services. For further information, call the Med Chi Library at 410-539-0872 or 1-800-492-1056.

Med Chi Publishes Child Maltreatment Manual

As part of the *Maryland Physicians' Campaign Against Family Violence*, Med Chi, in conjunction with the Maryland Alliance Against Family Violence, has published the second in a series of three manuals on family violence. Entitled "Child Maltreatment," the manual is a comprehensive guide for practicing physicians on how recognize, treat, and refer victims of child maltreatment. The manual will be mailed to all Med Chi members in the

near future. Physicians can earn four Category 1 CME credits for reviewing the manual and accurately completing the CME questionnaire that accompanies it.

Recommendations Issued on Stroke Prevention

Based on findings of the Secondary and Tertiary Prevention of Stroke Patient Outcome Research Team, the Agency for Health Care Policy and Research (AHCPR) has issued stroke prevention recommendations for clinicians and consumers. AHCPR says the key message of these findings is that medical treatments now make strokes as preventable as heart attacks. For copies of *Research Findings for Consumers: What You Should Know about Stroke Prevention* or *Research Findings for Clinicians: Stroke Prevention Recommendations*, call the AHCPR Publications Clearinghouse at 1-800-358-9295. The publications are also available through InstantFax at 301-594-2800.

CDC Issues Recommendations for Curbing Spread of Vancomycin Resistance

Since 1989, hospitals throughout the United States have experienced an increase in the incidence of infection by vancomycin-resistant enterococci (VRE). As a result, the CDC has issued *Recommendations for Preventing the Spread of Vancomycin Resistance*. Copies of the report can be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC, 20402-9325; telephone 202-783-3238.

Volunteers Needed for Study of Acupuncture and Knee Pain

The University of Maryland Medical Center is looking for men and women aged 50 or older who have been diagnosed with osteoarthritis of the knee for at least six months to participate in a study to evaluate the effectiveness of acupuncture. Participants must have had at least moderate pain in the knee almost daily during the last month and must also be taking some type of medication to control pain. As part of the study, participants will receive treatment free of charge. For further information, call 410-706-3733.



Angelo J. Troisi, F.A.C.H.E.
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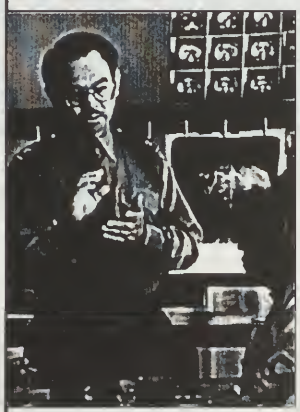
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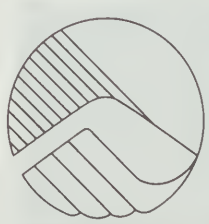
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Physician Rehabilitation Committee

Members in the News



ARTHUR BAITCH, M.D., has been elected chairman of the board of directors of the Northwest Hospital Center in Randallstown, Maryland. Dr. Baitch graduated from the University of Maryland School of Medicine. His postgraduate training was at Sinai Hospital of Baltimore and the Philadelphia General Hospital. After internship, he served in the U.S. Air Force as a flight surgeon. A former president of the Maryland Orthopaedic Society and chief of staff at the Northwest Hospital Center, Dr. Baitch is a professor emeritus in the department of orthopedic surgery at The Johns Hopkins University School of Medicine. He is in the private practice of orthopedic surgery.



DONALD H. DEMBO, M.D., immediate past president of Med Chi, has recently been named associate physician-in-chief at Sinai Hospital of Baltimore. A cardiologist, Dr. Dembo will provide medical leadership for satellite practices and the quality assurance program; provide oversight of the division of cardiology; assist with physician recruitment; and teach medical residents, interns, and students. A graduate of the University of Maryland Medical School, Dr. Dembo completed graduate training in internal medicine and served in the army as assistant cardiologist for the European Theater of Operations. He returned to an American Heart Association research fellowship in cardiology at the University of Maryland and then became chief of cardiology at Maryland General Hospital in Baltimore. During his 31 years at Maryland General, Dr. Dembo established the first dedicated catheterization laboratory in a community hospital, the first coronary care unit in a Baltimore hospital, and inserted the first permanent cardiac pacemaker in this area. In addition, he was chief of cardiovascular medicine at Good Samaritan Hospital in Baltimore and was an assistant professor of medicine at the University of Maryland. Dr. Dembo is among the authors of the first CPR manuals on advanced life support and has written extensively on health care reform. He is an assistant professor of medicine at The Johns Hopkins University School of Medicine and has been the teaching scholar in cardiology at Sinai Hospital for the past three years.

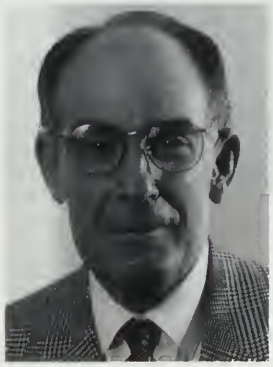


GEORGE ELIAS, M.D., a surgeon whose areas of expertise include head and neck tumors, breast cancer, gastrointestinal tumors, melanoma, soft tissue sarcomas, and solid tumors, has joined the staff of Franklin Square Hospital Center in Baltimore as chief of surgical oncology. A surgeon at the University of Maryland Hospital Center for twenty years, Dr. Elias will now be the principal investigator of the National Surgical Adjuvant Breast/Bowel Project, a national research project funded by the National Cancer Institute. In addition, Dr. Elias is working on a vaccine program for patients diagnosed with metastatic melanoma. President of the Maryland Chapter of the American College of Surgeons and recipient of many awards and research support, Dr. Elias is the author of *Handbook of Surgical Oncology*. He has written more than 120 scientific manuscripts, 65 abstracts, and 16 book chapters. Dr. Elias graduated from the Cairo University Medical School in Egypt and completed his residency at Union Memorial Hospital in Baltimore. He also earned master of science and doctor of philosophy degrees at the State University of New York at Buffalo.



GEORGE S. MALOUF, SR., M.D., a 35-year leader in the field of ophthalmology and public health in Maryland, is the recipient of the American Academy of Ophthalmology's Outstanding Humanitarian Service Award in 1995. Dr. Malouf, chairperson of the Maryland Health Resources

Planning Commission, was also one of the founding members of the Prince George's County Health Planning Advisory Committee. Former chief of ophthalmology at Prince George's County General and Doctor's hospitals, he was appointed a member of the board of directors at Prince George's General Hospital and Dimensions Inc., a corporation that oversees three county hospitals. Chairperson of the Maryland delegation to the American Medical Association and a member of the American Board of Ophthalmology, Dr. Malouf is a past president of Med Chi, the Prince George's County Medical Society, and the Maryland Society of Eye Physicians and Surgeons. Dr. Malouf received his medical degree from the French Faculty of Medicine in Beirut, Lebanon. After completing his residency training at Boston City Hospital, he served in the U.S. Army Medical Corps. Dr. Malouf and his two sons maintain a private practice in Hyattsville. In addition to his private practice, Dr. Malouf developed the Baden Health Services which serves thousands of rural Marylanders who would otherwise do without medical care. He also serves as a trustee of the Magruder Trust, which assists medically under-served children in Prince George's County who require medical care. Dr. Malouf has received many awards for his years of dedicated work in the health care community, including the AMA's distinguished Benjamin Rush Award for Citizenship and Community Service and the A. H. Robbins Award for Community Service. In 1988 he was named Prince Georgian of the Year.



NEIL B. ROSENSHEIN, M.D., former director of gynecologic oncology at The Johns Hopkins Hospital, was recently recruited by Mercy Medical Center to serve as director of its new Gynecologic Oncology Center. Dr. Rosenshein received his medical degree from the University of Florida Medical School and served his internship and residency in gynecology and obstetrics at The Johns Hopkins Hospital. He conducted his fellowship at Hopkins, with additional fellowship training at Memorial Sloan-Kettering Cancer Center in New York. Board certified by the American Board of Obstetrics in gynecologic oncology and a diplomate of the American Board of Obstetrics and Gynecology, Dr. Rosenshein is a fellow of the American College of Obstetricians and Gynecologists and the American College of Surgeons. He is also a member of several other professional and medical societies. Dr. Rosenshein is an associate professor of oncology and gynecology and obstetrics at The Johns Hopkins University School of Medicine and associate professor of epidemiology at Hopkins School of Public Health and Hygiene. He is the author of *Manual of Gynecologic Oncology* and more than 140 articles published worldwide. ■

ER is a top-rated television program created by a well-known novelist and medical school graduate, Michael Crichton. As a medical show, it has generated much interest.

What do you think of it? We would like to have your comments and critique.

Send them to: *MMJ* Reviews, 1211 Cathedral Street, Baltimore, MD 21201.

Speak Out

"Managing" to redefine psychiatry

Medical care in the United States increasingly is being provided through some form of managed care. As of 1993, the percentage of the population with some kind of managed care plan far exceeded that with indemnity coverage.[1] Patients who still have traditional indemnity plans also may be subject to prior approval for treatment and concurrent utilization reviews by managed care entities with whom the insurers contract. The rationale for this shift has been the belief that medical costs have exceeded what our society and economy can support and that much previous treatment was unnecessary. The insurance and managed care organizations have come to be the judge of what treatment is necessary, when it is necessary, the quality of that treatment, and the suitability of providing doctors. This is carried out not only in the name of cost containment, but in the name of ensuring high quality care.

This revolution has indeed brought about savings in the direct costs of medical care. As a result, employers, political leaders, and others increasingly support it. Managing medical care, however, has become a major industry. During 1993 and 1994, the pay to some managed care CEOs alone—including salary, bonuses, and stock options—has been reported to be multi-millions per CEO. It has been reported that many for-profit plans have accumulated significant liquid assets above and beyond their high compensation to executives, administrative costs, and stockholder dividends. Four of these companies are said to have accumulated more than $1 billion each in liquid assets.[1] The money to support all this comes from restricting care. A presumed flaw in the traditional fee-for-service approach was that it made it profitable to providers to supply excessive and unnecessary services. The flaw in managed care is that profits are derived by restricting and denying services. For psychiatric patients, the restrictions have often gone beyond medically responsible levels.

Managed care affects all areas of medicine, but it is *redefining* the practice of psychiatry. A plan that approves psychiatrists only for prescribing medication and not for psychotherapy is actually altering the practice of psychiatry. A reviewer who questions the need for psychiatric treatment because the "patient's problems are predominantly interpersonal" is expressing an altered concept of psychiatry. Psychiatrists are often restricted from doing more than what might be characterized as first aid, crisis management,

Reprints: Irvin H. Cohen, 7600 Osler Dr., Suite #400, Towson, MD 21204

Speak Out

and symptom suppression. Although in some cases that is all that can be accomplished, it does not address the needs of many other patients. Patients with complex personality disorders, deep-rooted neuroses, and other major psychiatric disorders cannot always be adequately helped through brief or infrequent treatment. They often require extended or more intensive treatment, which, being more costly, is often restricted on the grounds that it is not clinically indicated or sufficiently effective. The economic issue is addressed as if it were an issue of proper therapy. Therapists are pushed to change the type of treatment, to change medications, to reduce the frequency of sessions, or to terminate treatment.

> A middle-aged man who had been very active in his career became so anxious that he withdrew from the high level of work that he had been doing and restricted his interpersonal relationships to his father and one brother. When the therapist submitted the progress report, citing the patient's impoverished social and personal relationships, the reviewer responded that the patient's involvement with his relatives clearly demonstrated he was capable of interpersonal relationships and hence the need for continued therapy was questionable.

We are faced with the hypocrisy that through restriction from treatment, denial of treatment, blockage from hospital admission, and seriously abbreviated hospital stays, psychiatric patients are being protected from unnecessary care and assured high quality care. In fact, the quality of care or the best interests of patients do not appear to be serious considerations in restrictions established by managed care companies. (A similar imbalance in the clinical decision-making process is evident in obstetrics: physician influence has been so irrelevant in determining the appropriate length of hospital stay after childbirth that legislative action was needed to force insurers to allow postpartum women an additional day of hospital stay.)

A psychiatrist's assessment that a patient requires hospitalization may not be honored no matter how experienced the physician. Barriers to hospitalization often place the patient in jeopardy. The criteria for admission have approached what were once criteria for involuntary commitment: imminent danger to self or others. In other areas of medicine, death does not have to be imminent for the patient to qualify for hospital care.

> A 53-year-old woman with a history of many episodes of major depression, severe anxiety, and panic again became increasingly depressed over a two-year period, during which her condition gradually worsened despite treatment by psychotherapy and medication. She was unable to work and had suicidal ideation, agitation, and sleep disturbance. A month earlier, she had taken an overdose of her medication. She was being seen four times per

week by either a social worker or the psychiatrist. The patient and her husband called frequently in distress. Her board-certified psychiatrist, who had considerable experience in inpatient and outpatient treatment, considered that her life was in danger and sought hospitalization authorization from her managed care company. Authorization was denied with the advice that hospitalization was unnecessary and that more frequent outpatient visits would be sufficient or day hospital treatment should be considered. The patient's condition was so serious that the family financed her emergency admission to a psychiatric unit.

When a patient is admitted, there is pressure to make hospital stays as brief as possible. Although that is a legitimate goal, it should not override all other clinical considerations. Managed care reviewers press for excessively brief hospital stays by simply declaring that extended treatment is not medically necessary or not in keeping with the standards established by the managed care company. Up to now, reviewers have had little liability for outcomes and have not had to contend with the problems this creates for the patient, family, or treating doctor.

It has become necessary to decide the modality of treatment and length of hospital stay within time frames that are not consistent with what we know from experience or research. For example, experience shows that one cannot necessarily know for three or more weeks if a particular antidepressant will be effective. In hospital settings, managed care time allocations mean decisions about treatment changes may have to be made in days. Electroconvulsive therapy, a very effective treatment when indicated, often must be initiated unduly early during a hospital stay so that it can be carried out within time restrictions that are imposed to contain costs. It is disingenuous to claim that the restrictions are also to maintain or improve quality of care. Discharging the patient to outpatient care is often pressed when there has simply been an absence of verbally expressed suicidal intent or behavior for several days. It does not take psychiatric training and experience to make a decision about suicidality on such a basis. In fact, clinical experience has shown that some patients are more prone to suicide in the early stages of improvement than they were when profoundly slowed by the severity of the depression. The assessment must be made by a qualified clinician with knowledge about the nature and course of the disorder, not simply on the single issue of whether the patient has expressed suicidal ideas or plans. In addition, suicide is not the only indication for hospital care.

Outpatient psychiatric treatment is also intensely scrutinized with frequent requirements for treatment plans to be submitted for renewed approval of a period of treatment. The therapeutic care of the patient is

Speak Out

recurrently subject to alteration or discontinuation on every occasion that a renewed authorization for treatment is required. This interferes with the patient's ability to establish trust and a sense of confidence that treatment will not be summarily threatened. Individual psychotherapy seems to have come under special assault by managed care reviewers. Limitations are placed on the frequency of sessions and the duration of treatment. Necessity for treatment is presumably based on a scale of how impaired the individual is, as determined by overt "measurable" symptoms. Subjective distress is given little weight. Benefits are restricted or discontinued with claims that the patient is not sick enough to need treatment or that treatment is inadequate and does not meet the standards of the managed care company. Although these standards are presented as clinical standards, they are clearly derivatives of cost control. (In fact, there is already a cost-control mechanism in place that does not depend on the review process. Psychiatric patients pay out of pocket for a much larger portion of the cost of therapy than patients pay for any other medical treatment. For most patients, this is a significant hardship and a deterrent to the pursuit of frivolous or unnecessary treatment.)

Professional training is being affected as well. The present form of managed care in psychiatry is inevitably shaping what psychiatric residents and other mental health trainees are learning about the nature of psychiatric illness and treatment. The basis for what look like clinical decisions is really the product of the managerial requirement. There is over-preoccupation with getting the patient out of the hospital or out of treatment. Before long, individuals who come out of training programs will know only this approach as the appropriate way to understand and deal with psychiatrically ill patients. The so-called knowledge to be learned about appropriate treatment will be coming from the reviewers and not from the clinic. The place of psychiatry as the specialty that deals with the experience of the person, psychic distress, and problems of functioning in human relationships is being lost. The importance of the doctor-patient relationship in psychiatric care is ignored.

> A patient who had been successfully treated for a severe depression over one year was told that she would have to stop seeing her psychiatrist and be followed by someone else when her employer changed to another plan offered by his insurer. This requirement ignored the value of the trust and confidence she had developed in her doctor and treated a change of doctors as if it were equivalent to changing from a brand name drug to a generic.

As now practiced, the managing of care diverts too high a proportion of the savings to profits for the companies, compromises the quality of care, usurps clinical judgment from the treating doctor, ignores the therapeutic value of the doctor-patient relationship, distorts the value and purpose of psychotherapy,

and affects the proper training experience of psychiatric residents and other personnel. The major victim is the patient. The specialty of psychiatry itself is being trivialized.

Refinement of the present system of managing psychiatric care is necessary. If managed care had a salutary effect on correcting the excesses of traditional care, it is now time to address the excesses of managed care itself. Establishing clinical standards of treatment is primarily a clinical matter, not a financial one. Judgments of quality and suitability of treatment are suspect if made by clinicians whose salaries come from insurance or managed care companies. The problem of funding must be addressed, but it should not be the prerogative of the insurer to establish standards of clinical care or to design the treatment. An unregulated managed care system allows excessive opportunity for profits through denial of care. Insurance benefits available must be clear from the start and not determined at the time of need. A plan developed with the above considerations in mind could allow for true competition among insurers and HMOs based on a clear knowledge of the benefits offered and the quality and reliability of the company's operation.

Irvin H. Cohen, M.D.
Towson, Maryland

Reference

1. Weiss B. Managed care: there's no stopping it now. *Medical Economics*, March 13. 1995:26–43. ■

Speak Out is a *Maryland Medical Journal* department created to enable readers to voice their opinions, convictions, or feelings about medicine and related subjects in a more lengthy format than is normally afforded by a letter to the editor. Please send Speak Out submissions, as well as letters to the editor and manuscripts, to the Editor, *MMJ*, 1211 Cathedral Street, Baltimore, MD 21201-5585.

LETTERS TO THE EDITOR

Wondering when sexism will disappear

After reading Dr. Mance's article in the August issue (Mance AE: Wondering. *Md Med J* 1995; 44:588-589), I am left wondering myself when the pervasive sexist attitudes and language in medicine will disappear. Though I appreciate the sentiment of his thoughts, as a female physician I am left feeling like an outsider.

Dr. Mance states that he became a servant to his "fellow man," that he knew who "his [the patient's] family and neighbors were," that he wonders how many of his "fellow physicians . . . visualize their real responsibility in caring for their fellow men." He wonders about the future welfare of his "fellow man," and then quotes a passage from the Hippocratic Oath including ". . . and the Practice of the Art . . . respected by all men. . . ."

I realize Dr. Mance cannot take responsibility for the language of Hippocrates, but I would hope that we have made some progress since then. As a student and resident I was constantly aware of sexist language, such as physicians and cardiac patients being referred to as "he" and pain and headache patients being referred to as "she." Now, as a practitioner, I am aware that this type of language continues to pervade meetings and conferences. Although it may seem harmless and although there is no malicious intent, the effect is to leave female physicians feeling like observers rather than participants. It takes extra effort to be conscious of and change our language, but a small change in language can create a large change in attitudes.

Carol L. Bowman-Jaffe, M.D.
Churchville, Maryland

Where are we going and why?

We, the American public, do not need insurance companies and big business to run our health care delivery system. Ever since they have been involved, the cost of health care has escalated much beyond what it should be. The most important bottom line is that the patient and our people are the ones receiving the brunt of this kind of health care delivery system.

Only a physician or health care provider should determine how, why, what, and for how long a patient should receive treatment. All health care professionals are under scrutiny at all times—by patients and from within their own peer system. These systems do work! We need to direct the care of the patient in a professional, loving, and caring way.

There should be multi-specialty practices, but under control of a health care professional who has a good business manager to handle the insurance coverage provided by the patient, not insurance companies and business ventures telling the health care providers how to care for the patients. Therefore, utilization review would not be necessary or needed as part of the care of a patient, no matter where the patient was treated.

Must everything be big business just for more people to make lots of money?

Let's get back to where we should be in the health care delivery system: physicians and health care providers working together as a team to make sure the patient gets the best care possible without outside forces, who only want to make money, interfering.

Rose Mary Hatem Bonsack, M.D.
Aberdeen, Maryland



On women in organized medicine

I had the pleasure of reading the brief article on women in organized medicine that appeared in the September issue (Short JH: A brief history of women and organized medicine. *Md Med J* 1995;44: 709-710). I am a board-certified orthopedic surgeon specializing in pediatric orthopedics. I was one of eight girls in my class at The University of Pennsylvania Medical School from which I graduated in 1955. After training in pediatrics and in general surgery in Baltimore at the Sinai Hospital, I returned to The University of Pennsylvania where I became the first woman to train in any field of surgery and the first woman to train in orthopedics.

I completed my residency and went into practice in 1960 and became the twelfth woman board certified in orthopedic surgery and to be accepted as a fellow in the American Academy of Orthopedic Surgeons, the certification coming in 1963 and entry into the Academy in 1964—both on the first occasion that I was actually eligible.

My father, Max Sokol, was a prominent trial attorney in this community. When I went into practice, he gave me a wonderful piece of advice. He sent me to see the late John Sargeant, who was then executive director of Med Chi. Mr. Sargeant gave me excellent advice both as to establishing my practice and to entry into the activities of organized medicine. I have remained active in Med Chi. I was active in the Baltimore City Medical Society and when I moved my office to Baltimore County, I became active there.

I am appalled at the reluctance of women to become involved in organized medicine. Too many of my colleagues are interested in complaining about their exclusion but not willing to become an active part of the organized community. Over the years, I have served on both the Peer Review Committee of the Baltimore County Medical Society and the Peer Review Committee of Med Chi. The experience gained at Med Chi enabled me to become the first president of The Ruth Jackson Society (national women's orthopedic group) and one of the founding members of the Pediatric Orthopedic Society of North America, which began with seven men and myself. There is no question in my mind that women can and should take leadership roles in Med Chi. I have always felt welcome and believe that other women would also be welcome if they were going to make the first move to be included.

Liebe S. Diamond, M.D.
Baltimore, Maryland

Letters To The Editor

The editorial board of the *Maryland Medical Journal* welcomes comments, criticisms, recommendations, and observations from all its readers. Please submit letters to

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Philip A. Mackowiak, M.D., is the lead author of a study of physicians' perceptions regarding body temperature in health and disease (*South Med J* 1995;88:934–938). Dr. Mackowiak is a professor of medicine and vice chairman of the department of medicine at the University of Maryland School of Medicine, and chief of the medical service of the Baltimore Veterans Affairs Medical Center.

Wayne M. Koch, M.D., Ding Jen Lee, M.D., David W. Eisele, M.D., Charles W. Cummings, M.D., and **Arlene Forastiere, M.D.,** are among the authors of a study indicating that the use of concurrent chemoradiotherapy as primary treatment for resectable head and neck squamous cell carcinoma was tolerated with good local control and survival (*Arch Otolaryngol Head Neck Surg* 1995;121:974–980). Drs. Koch, Eisele, Lee, and Forastiere are associate professors of otolaryngology-head and neck surgery, and Dr. Cummings is a professor and director of the department otolaryngology-head and neck surgery at The Johns Hopkins University School of Medicine.

A. Cahid Civelek, M.D., Elba M. Pacheco, M.D., and **Nicholas T. Iliff, M.D.,** are among the authors of a study to determine the usefulness of the bone scan for the evaluation and relative quantification of the vascularization of coralline hydroxyapatite ocular implants. Results, published in *Clinical Nuclear Medicine* (1995;9:779–787), indicate that the bone scan characteristics at 1 to 2 months were similar to those at 6 months, suggesting that the vascularization of the ocular hydroxyapatite implant may be complete as early as 1 to 2 months after implant surgery. Dr. Civelek is an associate professor of radiology, Dr. Pacheco is an assistant professor of ophthalmology, and Dr. Iliff is an associate professor of ophthalmology at the Johns Hopkins Medical Institutions.

Nathan G. Congdon, M.D. and Harry A. Quigley, M.D., of the Dana Center for Preventive Ophthalmology at the Johns Hopkins Medical Insitutions, are among the authors of a study to evaluate the impact of age, various forms of cataract, and visual acuity on whole-field scotopic sensitivity screening for glaucoma in a rural population. Results indicate that although cataract affects the whole-field scotopic threshold, scotopic testing may be of value in field-based glaucoma screening (*Arch Ophthalmol* 1995;113:1138–1143).

John L. Carroll, M.D., and **Gerald M. Loughlin, M.D.,** are among the authors of a study indicating that primary snoring cannot be distinguished from childhood obstructive sleep apnea syndrome by clinical history alone (*Chest* 1995;108:610–18). Dr. Carroll is an associate professor of pediatics and Dr. Loughlin is a professor of pediatrics at The Johns Hopkins Children's Center.

Mark J. Krasna, M.D., Charles S. White, M.D., and **Joseph S. McLaughlin, M.D.,** are among the authors of a case report describing a subarachnoid-pleural fistula that led to persistent pneumocephaly in a patient who exhibited postoperative hyponatremia, confusion, and gait disturbance (*Ann Thorac Surg* 1995; 60:683–5). Dr. Krasna is director of general thoracic surgery, Dr. White is an assistant professor of thoracic surgery, and Dr. McLaughlin is a professor and head of thoracic cardiovascular surgery at the University of Maryland Medical Center.

Robert E. Black, M.D., M.P.H., of the department of international health at The Johns Hopkins University School of Hygiene and Public Health, is among the authors of a study indicating that zinc supplementation may result in clinically important reductions in the duration and severity of acute diarrhea in infants and young children (*N Engl J Med* 1995;333:839-844).

Eric B. Bass, M.D., M.P.H., an associate professor of medicine at The Johns Hopkins University School of Medicine, is among the authors of an article on how to use clinical practice guidelines (*JAMA* 1995;274:570–574).

Thomas D. Kirsch, M.D., M.P.H., an assistant professor of emergency medicine at the Johns Hopkins Medical Institutions, is the lead author of a study to analyze the emergency medicine system in a developing country and identify areas of need and potential collaboration. Results, reported in the *Annals of Emergency Medicine* (1995;26:361–367), indicate that the ED and prehospital systems provide high-volume and often high-acuteness care. Barriers to improved care include limited specialized training and lack of medical records.

Peter C. Belitsos, M.D., Richard E. Chaisson, M.D., and **Richard D. Moore, M.D.,** are among the authors of a study to quantitate the incidence of hepatic steatosis syndrome in a well-characterized, demographically heterogeneous cohort of HIV-infected patients followed longitudinally. Results indicate that the syndrome, manifesting as a severe, potentially fatal complication of antiretroviral therapy in HIV disease, is rare (*Am J Gastroenterol* 1995;90: 1433–1436). Dr. Belitsos is an assistant professor of medicine, and Drs. Chaisson and Moore are associate professors of medicine at The Johns Hopkins University School of Medicine.

Bonita Stanton, M.D., a professor of pediatrics at the University of Maryland Medical Center, is among the authors of a study indicating that from 1973 to 1992, rates of victimization from all types of violent crime increased among adolescents and young adults aged 10 to 25, regardless of gender or race. Absolute rates were highest among African Americans and males (*Arch Pediatr Adolesc Med* 1995;149: 953–960).

Michele D. Wilson, M.D., and **Alain Joffe, M.D., M.P.H.,** are among the authors of a study to compare outcomes among adolescents who use levonorgestrel implants, oral contraceptives, or other methods of birth control. They found that the levonorgestrel implant is an effective method of pregnancy prevention and is associated with high satisfaction and continuation rates at 6 months (*Arch Pediatr Adolesc Med* 1995; 149:967–72). Drs. Wilson and Joffe are with the department of pediatrics at the Johns Hopkins Medical Institutions.

Paul A. Watkins, M.D., Ph.D., Gerald V. Raymond, M.D., and **Hugo W. Moser, M.D.,** are among the authors of a study to examine the clinical distinction between patients with a disorder of peroxisome assembly (e.g., Zellweger syndrome) and those with a defect in a peroxisomal fatty acid ß-oxidation enzyme. Results indicate that BIF deficiency can be distinguished from AOx deficiency on the basis of clinical and biochemical findings, facilitating early diagnosis without the need for complementation analysis (*Ann Neurol* 1995;38:472–7). Dr. Watkins is an associate professor of neurology, Dr. Raymond is an instructor in neurology, and Dr. Moser is a professor of neurology at The Johns Hopkins University School of Medicine.

Jeffrey A. Brinker, M.D., a professor of medicine at The Johns Hopkins University School of Medicine, is among the authors of a study to determine if complications associated with heparin used during and after coronary angioplasty to prevent closure of the dilated vessel could be prevented when the direct thrombin inhibitor bivalirudin (Hirulog) is used in its place. Bivalirudin reduced the risk of immediate ischemic complications in patients with postinfarction angina, but the difference was no longer apparent after six months (*N Engl J Med* 1995;333:764–9).

"Those whom we seek to serve come our way but once as boys. We must not neglect any of them, for somewhere among them may be one who will lead this world to everlasting peace."
Lord Baden-Powell

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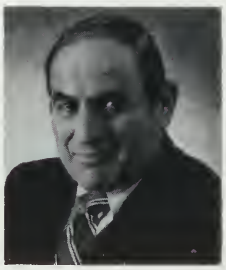
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Chaired By



Morton I. Rapoport, M.D.
University of Maryland Medical System

Wednesday, December 13, 1995

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- "I Was Dying To Be Thin"
  Seventeen, November 1995
- "Figuring out Fever—What To Do and What Not To Do When Your Child's Temperature Rises"
  Working Woman, November 1995
- "Keeping Secrets—Why Black Men Are Still Reluctant to Seek Therapy"
  Essence, November 1995
- "Natural Remedies for Childhood Diseases"
  Mothering, Winter 1995
- "To Be Healthy You Must Work Out Everyday . . . And Other Fitness Myths"
  American Health, November 1995
- "What to Expect When Your Child is Hospitalized"
  Child, November 1995
- "Finding the Right Care: Top Doctors"
  Washingtonian, November 1995
- "Coming To Terms With C-Section"
  Parenting, November 1995
- "Should an AIDS Test Be Required for All Pregnant Women?"
  Glamour, November 1995
- "A Shot in the Arm—With Flu Season Approaching and an Ongoing Risk of Hepatitis, Who Needs Vaccinations?"
  Out, November 1995
- "New Hopes for Depression"
  New Women, November 1995
- "The News on Liposuction"
  Self, November 1995
- "Why Is America So Fat?"
  Fit, December 1995
- "Cosmo's Update on Antibiotics"
  Cosmopolitan, November 1995
- "Impotence: A New Hope"
  Urban Fitness, Vol. 1 No. 3
- "The Most Misused Medicine in America"
  Good Housekeeping, November 1995
- "Fat: How Much Your Child Really Needs"
  Child, November 1995
- "Take Your Phytomins"
  Mens Health, November 1995
- "Homeopathy and Childhood Diseases"
  Mothering, Winter 1995
- "Avoiding Anaemia"
  Pride, August/September 1995
- "The Latest and Greatest Obesity Gene"
  Muscular, January 1996
- "Seasonal Sadness and What You Can Do About It"
  Self, November 1995
- "Ultrasound: More Harm than Good?"
  Mothering, Winter 1995
- "At Risk—Medicaid Reform Threatens Benefits for People with AIDs and HIV Infection"
  The Advocate, October 31, 1995

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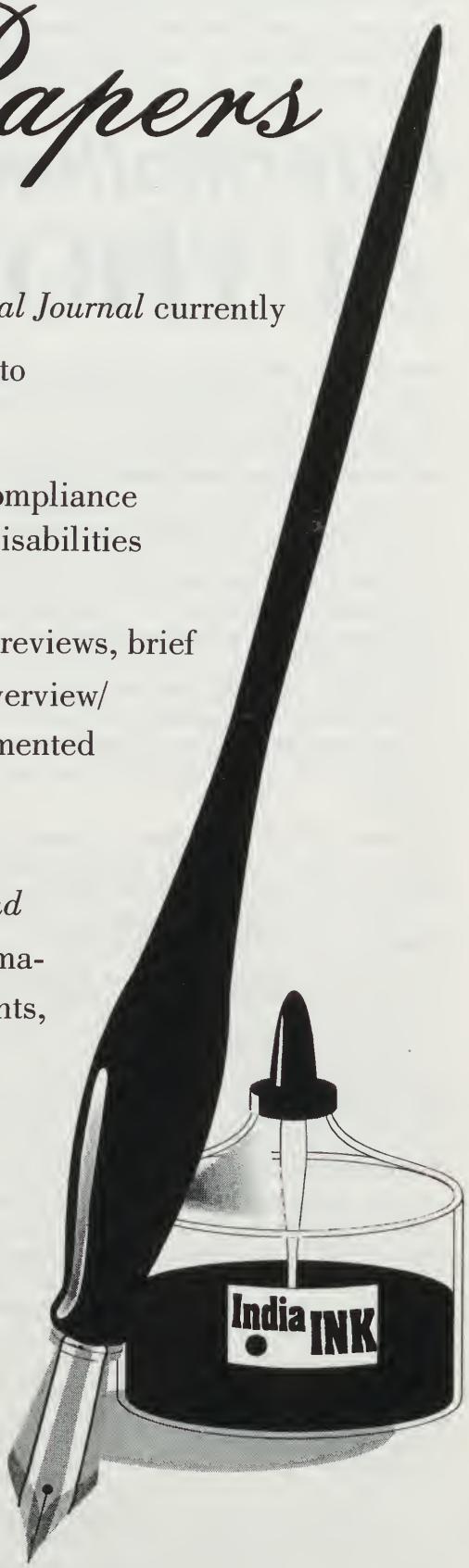
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Malaria, an unclear but present danger

Gilbert Burnham, M.D., Ph.D.

Dr. Burnham is an assistant professor in the department of international health at The Johns Hopkins University School of Hygiene and Public Health.

ABSTRACT: *Malaria is an ever present danger to those who travel in endemic areas. Falciparum malaria may be a life-threatening condition, even when treated promptly and appropriately. It is important that practitioners be aware that international travelers are at risk for malaria. It is also important to advise patients to seek expert advice on malaria prevention before they travel to malarious areas.*

People from the United States who travel to developing countries or immigrants from these areas may bring back a variety of exotic diseases. Although the consequences of many of these infections may be severe, few are associated with such an urgent need for prompt diagnosis and treatment as malaria. The chances that a Maryland practitioner will encounter undiagnosed malaria increases year by year. The number of primary malaria cases reported to the Centers for Disease Control and Prevention (CDC) among U.S. civilians has increased some six-fold during the past 25 years; 585 cases were reported in 1991, the last year for which figures are published.[1] In 1991, there were 439 cases of malaria among foreign citizens (fairly steady for 12 years), and 22 cases among military personnel (largely unchanged since 1973). Of the total of 1098 U.S. cases for 1991, 53 persons in Maryland were diagnosed with malaria. During a 10-year period ending in 1992, 64 children with malaria were admitted to the Children's National Medical Center in Washington, DC. Of these, two thirds were U.S. citizens who had acquired infection in Africa.[2]

The clinical spectrum of malaria ranges from low-grade indolent fever associated with malaise and loss of appetite in the case of infection with the so-called benign species, to rapid deterioration and death in the case of *Plasmodium falciparum*. In many cases, an inadequate travel history

results in valuable time lost in establishing the diagnosis. The following case report is presented to remind practitioners to consider malaria in any febrile person returning from an endemic area, and to illustrate that even with prompt diagnosis and treatment, the course of malaria may be life-threatening.

Case report

A 62-year-old man who previously had been in good health returned to Baltimore after a three-week visit to Uganda complaining of feeling unwell for six days. The episode had begun in Kampala with fever, poor appetite, headache, and malaise. During the next several days, fever persisted with increasing weakness. Dark urine was observed on day two. During the previous week he had begun malaria chemoprophylaxis with 300 mg chloroquine base. After the second day of fever, he began self-medication with "curative" doses of chloroquine. By day four, when he arrived in Maryland, he had taken 1500 mg chloroquine base, close to the recommended treatment dose of 25 mg/kg for chloroquine-sensitive malaria.

When the patient arrived in Maryland, his temperature was 102° F, and his wife thought he looked gray. The following day, his temperature was 103° F, and he noted some chest tightness. On day six, he had a thin blood film done on his way to see his regular physician because the hospital laboratory was unable to do the standard thick films. Physical examination showed mild jaundice and tenderness over the liver. The hematocrit was 34%, the white-cell count 7000, and the platelet count 17 000. Total bilirubin was 102 μmol/L, most unconjugated. The thin film was reported to show 10% of red cells parasitized by *P. falciparum*, a very high level that was later revised downward.

The patient was hospitalized and after a consultation with the CDC, he was started on oral quinine and doxycycline for treatment of chloroquine-resistant malaria. On the second hospital day, he experienced some shortness of breath. A chest radiograph showed a small infiltrate. By the third hospital day, the patient was increasingly short of breath, becoming weaker, and was intermittently confused. His blood film was now free of malaria parasites. He was transferred to an intensive care unit, where intravenous quinidine 650 mg every eight hours and nasal oxygen were started. A repeat chest radiograph showed bilateral basal infiltrates. Because of poor oxygen saturation, continuous positive alveolar pressure was started. On the fourth hospital day, pulmonary infiltrates worsened as shown by a chest radiograph, and the patient developed a supraventricular tachycardia. Quinidine was continued, and sefuzoxin and erythromycin were added. The patient's breathing and oxygen saturation began to improve, although infiltrates worsened as shown on a chest radiograph. Cardioversion on day five failed, but transvenous pacing restored normal sinus rhythm. By day six, the fever subsided, but the patient became querulous, fearful, and confused. By day eight, he was breathing easily and was transferred out of the intensive care ward. He subsequently made a full recovery and resumed his professional responsibilities.

Discussion

Malaria is a real risk to the increasing numbers of U.S. citizens who travel abroad each year. Fatalities continue to occur in those who return with *P. falciparum*. Many persons with the more benign forms, *P vivax*, *P. ovale*, and *P. malariae*, suffer persisting low-grade symptoms until the diagnosis is eventually made. Forty percent of the world's population live in areas where malaria transmission may occur. Ten percent live where malaria remains holoendemic or hyperendemic.[3] Much of this population is in sub-Saharan Africa, where most returning U.S. citizens acquire their malarial infections.

Plasmodium vivax is the most widespread of malaria species. Infection with so-called benign malaria (*P vivax*, *P. ovale*, and *P. malariae*) may cause fever, headache, back and joint pains, and malaise and loss of appetite. The often-indolent nature of these infections and the paucity of parasites on blood films make them sometimes difficult to diagnose. *P vivax* and *P. malaria* are characterized by sporozoites (hypnozoites) that may remain dormant in the liver and give rise to relapses up to 20 years after the initial infection.

Almost all the mortality associated with malaria is due to *P. falciparum*, which is most prevalent in Southeast Asia and Africa. Expatriate visitors and residents as well as some nationals of countries where malaria is holoendemic lack the partial immunity that protects against complicated falciparum malaria.

Complications

Serious complications include cerebral malaria, adult respiratory distress syndrome (ARDS) or "malarial lung," and renal failure. Multiple organ dysfunction due to falciparum malaria is common, often with fatal a outcome.[4]

In the case described above, the low platelet count on admission suggested a serious infection. The decreased hematocrit and elevated unconjugated bilirubin provided evidence of a high parasite count causing substantial hemolysis. Parasite counts in peripheral blood smears may not correspond with the seriousness of the disease. Red blood cells parasitized with *P. falciparum* develop a cytoadherence that causes sequestration of these cells along the venular endothelium of internal organs.[5] In the brain particularly, this margination causes slugging in the capillaries that results in anoxia and often death.[6]

Cerebral malaria is one of the most feared complications. It presents as alterations in levels of consciousness that range from delirium and confusion to deep coma. In endemic countries, it is a major cause of morbidity and mortality among the nonimmune (primarily young children).

Acute pulmonary edema is a complication of falciparum malaria that resembles ARDS. It is frequently fatal.[7-9] In patients with high parasite counts, it often begins within a few days of treatment initiation. It is associated with increased permeability of pulmonary capillaries.[10,11] The sudden release of a large load of malarial antigens may be in some way responsible. Although exchange transfusion has been recommended in severe malaria,[12] it is a procedure not without risk, and its indications are not always clear.[13,14]

Renal failure is another complication often seen in falciparum malaria. Several factors probably play a role, including dehydration with increased blood viscosity. During the acute stage of malaria, cortical perfusion is reduced.[15] Massive hemolysis may release substances other than hemoglobin, which can induce acute tubular necrosis, especially if accompanied by hypovolemia and acidosis.[10]

Although thrombocytopenia is common in malaria, disseminated intravascular coagulation is only occasionally observed in complicated malaria. Prompt antimalarial treatment usually resolves coagulation abnormalities. Anticoagulation treatment poses unnecessary risks without offering proven benefits.

Hypoglycemia is common in severe malaria and should be anticipated during treatment. It is a manifestation of the disease, however, not a consequence of quinine therapy.[16]

Therapy

The most important determinant for a good outcome in complicated malaria is early recognition and prompt and vigorous treatment. In the United States and also in the United Kingdom, the diagnosis of malaria is made on average within 4.3 days of the first symptom. In fatal cases, the time to diagnosis was 6.9 days. About 50% of nonfatal and 20% of fatal cases of falciparum malaria were correctly diagnosed by three days after symptoms first appeared. Misdiagnosis at the first medical consultation occurred in 40% of fatal malaria cases.[17,18] Treatment with continuous intravenous quinidine (United States) or quinine (elsewhere) following a loading dose in the intensive care unit is the established treatment for severe malaria. Quinine or quinidine should be continued for seven days, but may be changed to oral administration when parasites have cleared from the blood and the patient is responding well.

Prevention

Approximately 25 to 30 million people from nontropical countries visit malaria-endemic countries each year; the majority are tourists.[19] Many of these visitors remain in urban areas where their risk of malaria may be minimal. Among U.S. travelers to malarious areas, however, certain groups are at particularly high risk. The largest group to become infected comprised people visiting friends or relatives in malaria-endemic areas of Africa.[1] Tourists, missionaries, and business representatives accounted for most of the other infections reported.[20] In general, young adult men are much more likely to acquire malaria than similarly aged women, at least in West Africa. As might be expected, the length of stay in a malarious area is directly related to the risk of developing malaria on return.[21]

Mefloquine or doxycycline are now the principal drugs for chemoprophylaxis. Chemoprophylaxis is generally very effective against malaria, but is only part of personal protection against malaria which may include repellants, bed nets, vaporized pyrethroids, and behavior that lessens potential contact with mosquitos. Travelers need individualized advice suitable to their destination, length of stay, and potential exposure to malaria transmission. In Maryland, advice on malaria prevention for travelers is available from travel clinics at The Johns Hopkins Hospital and the University of Maryland Medical Center. Travelers to areas where the risk of infection is high and access to competent medical services is uncertain should consider taking with them stand-by malaria treatment in case they develop fever or flu-like symptoms.[22]

Conclusion

Preventable deaths from imported malaria occur almost every year. Practitioners should consider the possibility of malaria in any immigrant or returning traveler and move promptly to exclude malaria in those with unexplained fever or flu-like symptoms. People who plan to travel to areas where malaria is endemic should receive expert, individualized advice about how to protect themselves from malaria infection.

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Hepatitis A vaccine

Virtually 100% of children, adolescents, and adults develop protective levels of antibody to hepatitis A virus after completing the recommended series of vaccinations with Havrix, an inactivated vaccine licensed by the FDA in February 1995. Vaccine recipients who have been followed for as long as four years still have protective levels of antibody, and kinetic models of antibody decline indicate that protective antibody levels could persist for at least 20 years.

Licensed for use in those aged 2 and up, Havrix is available in adult and pediatric formulations, with different dosage and administration schedules. It should be administered by intramuscular injection into the deltoid muscle. It can be administered with other vaccines and toxoids (hepatitis B, diphtheria, tetanus, oral typhoid, cholera, Japanese encephalitis, rabies, yellow fever) without affecting immunogenicity or increasing the frequency of adverse events. During simultaneous administration, however, the vaccines should be given at separate injection sites. When immune globulin (IG) and Havrix are given concurrently, the proportion of persons who develop protective levels of hepatitis A antibody is not affected, but antibody concentrations are low. The reduced immunogenicity is not expected to be clinically significant, however, because the final antibody concentrations are substantially higher than those considered to be protective. Vaccination of an immune person is not contraindicated and does not increase the risk for adverse effects.

The Advisory Committee on Immunization Practices offers the following recommendations for travelers to countries *other than* Australia, Canada, Japan, New Zealand, and countries in Western Europe and Scandinavia:

- All susceptible persons should be vaccinated with hepatitis A vaccine or receive IG before departure. The vaccine is recommended for those who travel repeatedly to or live for long periods in high-risk areas. For children younger than age 2, IG is recommended.
- The initial dose of vaccine is considered protective for 4 weeks. For long-term protection, the second dose is needed 6 to 12 months later. For those traveling to high-risk areas less than 4 weeks after the initial vaccine dose, the vaccine should be administered simultaneously with IG at different injection sites.
- A single dose of IG provides effective protection against hepatitis A for up to three months.

For additional information, call the CDC's Hepatitis Branch, Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases, at 404-639-3048.

Source: *MMWR Morb Mortal Wkly Rep* 1995;44:559-560.

Cigarette smoking and bladder cancer in Washington County, Maryland: ammunition for health educators

Patrick V. McCarthy, Ph.D., M.P.H., Anita J. Bhatia, Ph.D., M.P.H., Seang-Mei Saw, M.B.B.S., M.P.H., Jonathan D. Mosley, B.S., and Amarilys Vega-Quiñones, M.D., M.P.H.

At the time this paper was written, the authors were enrolled in the Master of Public Health program at The Johns Hopkins University School of Hygiene and Public Health.

ABSTRACT: *To investigate the frequency of cigarette smoking in patients who have been diagnosed with bladder cancer, data were obtained for 1507 subjects listed in the 1975 private census of Washington County, Maryland. Case subjects were defined as persons at least 18 years of age diagnosed with bladder cancer (ICD code = 188.0 to 188.9) between 1975 and 1992 for whom smoking information was available. Control subjects were defined as a random sample of persons frequency matched by age and sex to the cases. Controls were free of bladder cancer and had smoking information available. The odds ratio for current smokers for the association between smoking and bladder cancer adjusted for age and sex was statistically significant (OR = 1.68, 95% confidence intervals, 1.22 to 2.32). The chi-square trend test of the dose-response results was significant (chi-square = 11.69, df = 1, P .01).*

In 1986, the International Agency for Research on Cancer concluded that cigarette smoking is a cause of bladder cancer.[1] In 1987, the Surgeon General of the United States estimated that cigarette smoking could account for 47% of bladder cancer deaths in males and 37% of bladder cancer deaths in females.[2] In 1990, the Surgeon General stated that cigarette smoking is causally associated with bladder cancer.[3] Relative risk estimates that range between 1.0 and 7.2 have been reported for bladder cancer in current tobacco smokers compared to never-smokers.[3,4] The known bladder carcinogens (2-naphthlamine and 4-aminobiphenyl) which are known to be contained in cigarette smoke may account for the increased risk of bladder cancer observed in cigarette smokers.[5,6]

Since the causal association of bladder cancer and cigarette smoking has been established for the general United States population, it is helpful to see how the association applies for the residents of a Maryland county. A positive association between smoking and bladder cancer in a local area will allow health professionals to use more specific and more "personalized" health messages to reduce smoking and the attendant risk of bladder and other cancers.

Methods and subjects

A large portion of Washington County is rural. The major urban area is Hagerstown.[7] Washington County has few industries with known carcinogens.[8] The 1975 private census of the county obtained information on 90% of the 89,457 residents.[7] The data included information on smoking history and several demographic variables as of 1975 and on urinary tract neoplasms diagnosed between 1975 and 1992. Since bladder cancer occurs more often in older persons and in males compared to females, an age-sex-matched case-control study design was used to reduce the possibility of confounding due to age and sex. Cancer diagnosis data, starting with the year 1948, were obtained from Washington County Hospital discharge records and from death certificates of Washington County residents. Case subjects were defined as all persons at least 18 years of age who were diagnosed as developing bladder cancer (ICD code = 188.0 to 188.9) between 1975 and 1992 for whom smoking information was available. Control subjects were defined as a random sample of persons frequency matched by age (within 5-year age groups) and sex to the cases. Controls were free of bladder cancer during the study period and had baseline smoking information available. Data were obtained from 302 bladder cancer subjects and 1205 controls listed in the 1975 private census of Washington County, Maryland. Ten subjects (1 case and 9 controls) were subsequently dropped from all analyses because of missing smoking data. A systematic search of the census data to catalog all cases with smoking information available resulted in the identification of 217 male and 84 female cases. Four controls were selected for each case and included 860 males and 336 females.

Table 1. Sociodemographic data for cases with bladder cancer and controls[a] without bladder cancer, Washington County, Maryland, 1975

Variable	Cases		Controls	
	Number	(%)	Number	(%)
• Sample size	301	(20.1)	1196	(79.9)
• Age (years, mean in 1975)	59.9		59.9	
• Age (years, mean at diagnosis of bladder cancer)	69.4			
• Sex				
male	217	(72.1)	860	(71.9)
female	84	(27.9)	336	(28.1)
• Race				
white	299	(99.3)	1175	(98.2)
nonwhite	2	(0.7)	20	(1.7)
unknown	0	(0.0)	1	(0.1)
• Marital status				
single	12	(4.0)	60	(5.0)
married	288	(95.7)	1136	(95.0)
unknown	1	(0.3)	0	(0.0)
• Years of school				
< 12	172	(57.1)	709	(59.3)
12	87	(28.9)	296	(24.7)
> 12	40	(13.3)	177	(14.8)
unknown	2	(0.7)	14	(1.2)
• Smoking status[b]				
never smoked	90	(29.9)	468	(39.1)
former smoker	91	(30.2)	357	(29.8)
current smoker	120	(39.9)	371	(31.0)

a selected by frequency matching by age (within 5 year age-groups) and sex.
b never smoked includes 102 (17 cases, 85 controls) current and former pipe and cigar smokers. Odds ratio for bladder cancer and pipe/cigar smoking is not significant (OR = 1.05, 95% CI: 0.56 to 1.94).

The "never smoked" strata shown in **Table 1** includes 102 (17 cases, 85 controls) current and former pipe and cigar smokers. Defining the "never smoked" group in this way results in a larger number of cases and controls in the reference group and a more conservative odds ratio. The odds ratio for bladder cancer and the combined group of pipe/cigar smokers was not significant (OR = 1.05, 95% confidence intervals [CIs]: 0.56 to 1.94). Data were ana-

lyzed using Epi-Info version 5.01b computer software.[9]

Results

Table 1 shows that the percent distributions of the sociodemographic data for the 301 cases and the 1196 controls by age, sex, race, marital status, and years of school are similar. In subjects diagnosed with bladder cancer, the mean age at diagnosis was 69.4 years (range 30 to 97 years). The percent of case subjects who never smoked (29.9%) was less than the percent of control subjects who never smoked (39.1%). The percent of current smokers was higher in the cases (39.9%) compared to controls (31%).

Table 2. Odds ratios and 95% confidence intervals for the association of bladder cancer and smoking status

Variable	No. Cases	No. Controls	Odds Ratio[a]	95% CI
Smoking				
• status[b]				
never smoked	90	468	1.00	
former smoker	91	357	1.33	0.95 to 1.68
current smoker	120	371	1.68	1.22 to 2.32
• Dose-response[c] (cigarettes/day)				
< 14	24	82	1.52	0.88 to 2.61
15 to 24	52	168	1.61	1.07 to 2.41
> 24	41	109	1.95	1.25 to 3.07

[a] *adjusted for sex and age*
[b] *excludes 10 subjects (1 case, 9 controls) from all analyses due to missing smoking information*
[c] *excludes 15 subjects (3 cases, 12 controls) who are current smokers with unspecified levels of smoking*

Table 2 shows the odds ratios and 95% CIs for the association of bladder cancer and smoking status, and for the smoking dose-response relationship. When smoking is stratified by current and former smoking only, the odds ratio for the current smokers is statistically significant (OR = 1.68, 95% CI, 1.22 to 2.32). A chi-square trend test of the dose-response results for current smokers shows that as the number of cigarettes smoked per day increases, the risk of bladder cancer increases (chi-square = 11.69, df = 1, $P < .01$).

Discussion

Study results show that bladder cancer is related to cigarette smoking in Washington County residents. In addition, the study found a positive trend in the dose-response relationship between number of cigarettes smoked per day and the risk of bladder cancer. The relationship is stronger for current smokers than for former smokers, which suggests that smoking cessation may reduce the risk of bladder cancer. The results agree with the statement by the surgeon general that risk of bladder cancer declines after smoking cessation.[3] These results are also in agreement with those of several case-control studies cited in a review article by Dolin.[5]

The data set used in this investigation was not specifically developed to investigate the relationship of smoking and bladder cancer. As a result, many potentially important variables (e.g., family history of cancer, occupational exposure, consumption of known carcinogens, and temporal characteristics related to smoking such as age at initiation of smoking and continuity and intensity of smoking) were not available for analysis. The study was designed to minimize selection bias by taking cases and controls from the same reference population. Recall of smoking behavior was not a problem because smoking status was obtained by questionnaire in 1975 prior to disease status classification. However, self-reporting of smoking from household respondents could allow heavy smokers to under-report their daily cigarette consumption, or allow occasional smokers to deny their smoking behavior. Inaccurate reporting of smoking behavior could result in a misclassification bias and a less significant odds ratio than truly exists. Accuracy of diagnosis is independent of smoking status and should not affect the odds ratio.

Based upon the results of this study, health professionals will be able to state that there is a significant positive association between smoking and bladder cancer in one group of Maryland residents and that this association is probably causal. This information can be used to develop stronger, more specific, and more personalized health messages to reduce the incidence of bladder cancer in Maryland. A majority of smokers would try to quit smoking if they were specifically told to do so by their physician.[10] A strategy to reinforce orders to stop smoking should include explaining the dangers of smoking and the benefits of quitting, getting the patient to schedule a quit date, and helping to develop a cessation plan.[10,11] Some patients will require a referral to a smoking cessation program while others would benefit from self-help smoking cessation materials.[12] Patients can be prepared for withdrawal symptoms by receiving a prescrip-

tion for nicotine gum or skin patches.[13,14] When patients are advised to stop smoking, a follow-up visit or telephone call to reinforce cessation goals should be scheduled. The results of each smoking cessation consultation should be recorded in the medical record.[10]

A procedure to tag the records of smokers would help to remind providers to counsel smokers and set goals.[10] After the staff has been trained to give an explicit and consistent message to smokers, other personnel can assist with cessation maintenance counseling.[10] The staff can also help by keeping magazines that carry tobacco advertising out of the office.[15] Effective smoking cessation messages should address patient concerns and emphasize the short- and long-term health, social, and economic benefits of smoking cessation.[10] The message should be individualized to the patient's situation and different messages must be used for patients who have decided to quit and those who plan to continue smoking.[14] Effective messages take the form of personal advice that is direct, brief, and delivered face-to-face.[16] Health educators should promote the belief that it is possible to stop smoking and reassure patients who relapse that they will succeed if they persevere. It is not easy to stop smoking. Expect relapse, use your own skills to motivate, and do not give up on patients.[17]

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Mycobacterium marinum disease in Anne Arundel County: 1995 update

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ABSTRACT: *A retrospective survey of 41 cases of culture-positive* Mycobacterium marinum *disease in Anne Arundel County, Maryland, showed that most infection was related to recreational exposure to the Chesapeake Bay and its tributaries. Three quarters of cases consisted of skin or joint/tendon infection of the upper extremity, particularly the hand. An empiric drug regimen for a granulomatous soft tissue infection in this context should include rifampin and ethambutol or cotrimoxazole (trimethoprim/sulfamethoxazole). A reactive tuberculin skin test in Anne Arundel County is more likely to represent* M. marinum *infection than tuberculous infection.*

Mycobacterium marinum is an organism that usually causes skin and soft tissue infections which may persist for months to years and may resolve spontaneously or progress to tissue destruction. Infection occurs when a cut or abrasion is contaminated with water bearing the organisms.

As its name implies, the organism's natural habitat is water, particularly coastal waters, where it is a pathogen of fish. Its distribution is likely to be worldwide. Infections in humans have been reported from coastal areas of the Middle East,[1] the Far East,[2,3] and several countries in Europe, as well as from the United States. The Chesapeake Bay area has been known to be endemic for *M. marinum* since 1972,[4] when the epidemiology of this disease was first being investigated. Clusters of cases also have been reported from the Gulf of Mexico,[5] California,[6] and South Carolina.[7] The disease occurs rarely enough, however, that many physicians practicing locally have never seen a case.

All mycobacterial disease, not just tuberculosis, is reportable in Maryland. In recent years, the Anne Arundel County Department of Health has

Table 1. *M. marinum* susceptibilities 1988-94.

Antimicrobial	No. susceptible / no. tested	% susceptible
INH (high-dose)	1/37	3 %
RIF	37/37	100 %
EMB	37/37	100 %
Strep (high-dose)	18/37	49 %
PZA	1/3	33 %
Doxycycline	18/35	51 %
Minocycline	17/33	52 %
TMP/SXT	34/35	97 %
Clofazimine	35/35	100 %
Ciprofloxacin	17/19	89 %

received from two to ten disease reports of *M. marinum* annually.

Methods

The series consists of all 41 *M. marinum* isolates reported to the Anne Arundel County Health Department from area laboratories during the years 1988 to 1994. Almost all the isolates had been submitted to the state mycobacteriology laboratory for definitive identification and drug susceptibility testing. Telephone interviews using a structured questionnaire were conducted with physicians and patients. The physician questionnaire covered exposure, diagnostic measures, and treatment. Two physicians had moved out of county, and two declined to be interviewed. The study protocol was approved by the Institutional Review Board of the Maryland State Department of Health & Mental Hygiene. Informed consent was obtained from each patient or parent interviewed. Under Maryland law, when the health department receives a laboratory report, the patient can be contacted only with the consent of the attending physician. Seventeen patients had physician consent and could be located.

Results were analyzed by Epi.Info.5 software, using standard tests of significance.

Results

Of the 41 affected persons, 36 were male and 5 were female. Their average age was 44 (range, 2 to 79).

Laboratory data. By definition, a positive laboratory culture was obtained in each case. For 37 of the 41 isolates, antimicrobial susceptibilities were available. At the state mycobacteriology laboratory, routine susceptibilities included isoniazid (at two concentrations), rifampin, ethambutol, streptomycin (at two concentrations), clofazimine, doxycycline, minocycline, and cotrimoxazole (TMP/SXT); in the past four years, testing for ciprofloxacin has been added. Pyrazinamide (PZA) testing was successful for only three isolates. **Table 1** shows antimicrobial susceptibilities for all isolates for which testing was done.

Clinical data. Disease occurred in skin in 83% of patients, in a joint space in 17% of patients, and in tendon in 21% of patients (five patients had multi-tissue involvement). All disease was on the extremities, with the upper extremity—particularly the hand—affected more often than the lower extremity. Of 31 cases, 24 (77%) had lesions on the upper extremity; of these, 20 were on the hand or wrist.

Surgery, or surgical drainage, was performed in 14 patients. Tuberculin skin testing was performed in only two cases, both by the Mantoux technique: PPD readings were 2 mm and 18 mm of induration.

Sixteen patients were treated with antimicrobials. The most common regimens were RIF/EMB in ten patients, and minocycline in three patients; one patient each received cotrimoxazole, INH, and tetracycline.

Exposure. Two persons surveyed had occupational exposure: one was a biological technician at an ecological preserve, the other was employed in construction of piers. Almost the entire sample (39/41), however, lived within a quarter mile of the water (see **Figure 1**), and all seventeen who responded to the questionnaire engaged vigorously in water sports. All swam (or for the youngest, at least splashed) in the Chesapeake or its tributaries. In addition, most went fishing, sailing, crabbing, etc. Fourteen patients recalled a specific exposure incident (e.g., a cut while in the Chesapeake or its tributaries). A recurring incident was a cut while scraping barnacles off a boat. Incubation periods could not be established because patients had poor recall as to exactly when symptoms began.

Discussion

M. marinum infections are reported in Anne Arundel County with a predictable frequency of at least 1.3/100,000 population per year. The real incidence is likely to be higher. The current series includes all culture-proven cases, and mycobacterial cultures of skin lesions or chronic joint effusions are often not done. The true rate for *M. marinum* disease may be even higher than the incidence of active tuberculosis in Anne Arundel County, which in the past decade has stabilized at approximately 4/100,000 per year (Anne Arundel County Health Department Tuberculosis Control, 1987-1994, unpublished data.)

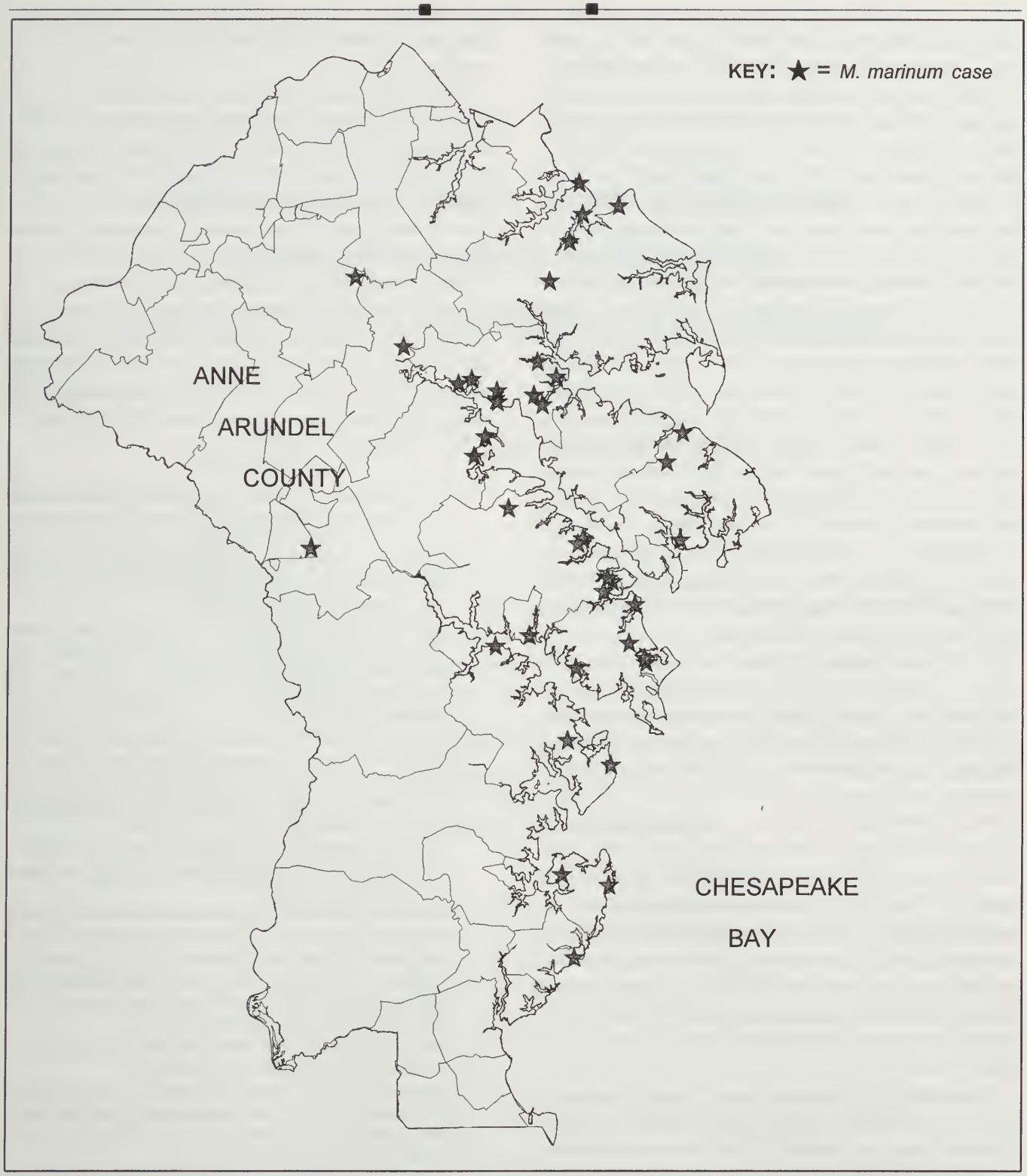


Figure 1. Geographical distribution of cases, 1988-1994

The endemnicity of *M. marinum* has ramifications for interpretation of tuberculin skin testing in Anne Arundel County. Previous studies have shown that tuberculin skin test responses in those infected with *M. marinum* are indistinguishable from tuberculin skin test responses in those infected with *M. tuberculosis*.[8,9,10] It is impossible to estimate the total number of *M. marinum* infected persons in the county. However, because of the notably low rates of active tuberculosis in Anne Arundel County, here a positive tuberculin skin test is more likely to reflect *M. marinum* infection than *M. tuberculosis* infection. The vast majority of active tuberculosis cases in the county are derived from a pool of persons infected in the remote past and not being substantially added to; only 3% of cases are contacts of

currently active cases (Anne Arundel County Health Department Tuberculosis Control, 1987-1994, unpublished data). The pool of *M. marinum*-infected persons is being added to constantly because of repeated exposure to the Chesapeake and its tributaries. Since *M. marinum* is not known to establish latency and result in late expression of disease, the incidence of acute disease is likely to reflect the incidence of new infection in any given year. Limited evidence suggests that most exposure does not result in disease, since nine of fourteen fishermen in an endemic area had immune reactivity against *M. marinum* antigens but no disease.[12] Over decades, the accumulation of new infections will yield a pool of *M. marinum*-infected persons that is orders of magnitude greater than the relatively stable pool of *M. tuberculosis*-infected persons. Little information is available on persistence of *M. marinum*-induced tuberculin skin test reactivity; however, one study found that in most cases the positive tuberculin skin test persisted for at least 12 years.[8] Specific studies would be needed to show definitively the relationship between *M. marinum* infection and tuberculin reactivity in Anne Arundel County. Only two persons in the current series had tuberculin skin testing, both by PPD; readings were 2 mm and 18 mm of induration.

It is this preponderance of cross-reacting skin tests, which will occur in any area of very low tuberculosis incidence, that underlies the public health recommendation that very low risk populations not be screened routinely and their skin test results not be considered significant until the induration is at least 15 mm.

Prior literature has associated *M. marinum* disease with exposure to fish tanks[6,11] and swimming pools before standards for pool disinfection were established.[9] Multiple case reports describe occupational exposure that resulted in *M. marinum* infection.[2,3,5] The current series includes only two patients with possible occupational exposure and one person who had any contact with a fish tank. In Anne Arundel County in the past decade, the majority of cases clearly derived from recreational exposure to the Chesapeake Bay and its tributaries.

The susceptibility pattern of Anne Arundel County isolates of *M. marinum* is well enough defined to provide guidance in empiric treatment. All isolates were susceptible to rifampin and ethambutol, making this combination the treatment of choice for presumptive *M. marinum* disease in Anne Arundel County. A popular alternative in the literature has been a tetracycline; however, since half our isolates were resistant to this class of antibiotics, it cannot be recommended here except with specific evidence of susceptibility. Cotrimoxazole is a reasonable alternative for empiric therapy since 97% of isolates were susceptible to this drug. Although 100% of isolates were susceptible to clofazimine *in vitro*, there are no clinical efficacy studies for this drug against *M. marinum*.

Finally, physicians (including dermatologists, rheumatologists, and especially hand surgeons) need to be aware of the relatively high incidence of *M. marinum* diseases in populations surrounding the Chesapeake Bay, and be prepared to look for it early in the evaluation of a chronic sporotrichoid, ulcerating, or verrucous skin lesion, or chronic joint effusion/tendinitis, particularly in the context of recreational exposure to the Chesapeake and its tributaries. Tissue and/or joint fluid should be obtained for mycobacterial culture, so that definitive susceptibilities may be established and therapy initiated before there is permanent structural damage. Empiric therapy with rifampin and ethambutol is warranted for any granulomatous lesion in this context.

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Case report: recurrence of chronic ulcerative colitis induced by intercurrent cytomegalic virus infection

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An association between cytomegalovirus (CMV) and idiopathic ulcerative colitis has been known for more than 30 years.[1] The CMV-associated colitis usually occurs in those who are either immunosuppressed or taking long-term corticosteroid drugs. We describe a patient who had been diagnosed with ulcerative colitis, who then developed a recurrence six months after glucocorticoid therapy was started. Despite tapering or increasing the glucocorticoid therapy, the symptoms did not improve. Investigations demonstrated the presence of CMV in tissue samples, increase in antibody titers to the CMV virus, and resolution of the colitis upon use of specific anti-CMV therapy.

Case report

A 19-year-old woman presented with the sudden onset of frequent bloody stools of ten days' duration. Family history was negative for inflammatory bowel disease or concurrent infectious diseases. Physical examination was unremarkable. Stool cultures were negative for *Salmonella*, *Shigella*, *Vibrio*, *Yersinia*, ova, and parasites. Hemogram showed the white-cell count was 7800 leukocytes/mm3, hemoglobin 13.6 g/dl, and hematocrit 40.2%. Colonoscopy demonstrated mild to moderate colitis extending from the rectum up to the level of the cecum, characterized by mucosal edema, hyperemia, and friability more marked in the left colon but present into the ascending colon. No mucosal ulcers or pseudopolyps were observed. Biopsies from the left colon showed chronic inflammatory changes with activity consistent with idiopathic ulcerative colitis. Prednisone 40 mg/day once daily and sulfasalazine by mouth were started, and the patient received 5-aminosalicylic acid enemas.

After two months of therapy, she underwent a colonoscopic follow-up examination that showed mucosal edema and erythema extending from the rectum to the proximal transverse colon. Clinically there had been improvement. The prednisone dosage was reduced to 20 mg/day. After four months, the patient stopped taking the medication on her own.

Two months later, she developed fever and right-sided abdominal cramping pain without diarrhea. Sulfasalazine and prednisone 40 mg/day were started. Abdominal examination demonstrated lower abdominal tenderness without guarding, rebound, or masses. Laboratory investigation showed a normal biochemical profile. A computerized tomagraphic scan of the abdomen showed no abnormalities. Colonoscopy, however, showed not only hyperemia, edema, and friability, but discrete ulcers in the sigmoid colon. There was extensive cobblestoning of the mucosal surfaces involving the distal two thirds of the transverse colon. Biopsies showed an active colitis and cryptitis and active vasculitis and numerous cells with CMV-like inclusion bodies which were stained positive for CMV antigen by immunocytochemical technique.

Withdrawal of prednisone therapy did not result in clinical improvement. Intravenous ganciclovir 300 mg every 12 hours was started and continued for 3 weeks. There resulted prompt clinical improvement with concomitant improvement in the colonoscopic findings and disappearance of the CMV inclusion cells on biopsy. Acute and convalescent serum samples showed that the CMV immunoglobulin G antibody increased from 32.9 American units (AU)/ml to 75.5 AU/ml (positive, more than 15 AU/ml).

Discussion

Evidence from case reports suggests that CMV infection of the bowel can initiate a mucosal disease indistinguishable from ulcerative colitis.[2] Clinically evident acquired CMV infection of the gastrointestinal tract can occur in persons with impaired immune function, such as that related to the use of immunosuppressant drugs, prolonged corticosteroid therapy, and acquired immune deficiency syndrome (AIDS).[3-5] Patients who have colonic CMV diseases may have diarrhea, hematochezia, abdominal pain, rectal urgency, and tenesmus. Associated constitutional symptoms (e.g., fever, malaise, anorexia, weight loss) are often present.[6] Diagnostic criteria for CMV colitis include one or both of the following: electron microscopic detection of the typical CMV virion and/or histologic detection of typical CMV cytopathology. Rise in antibody titer to CMV may be helpful.[7,8]

Our patient received no immunosuppressive therapy before the onset of her disease. In her initial biopsies, there was an absence of CMV inclusions. Furthermore, her clinical improvement during treatment with systemic steroid and sulfasalazine supports the likelihood that CMV was not a factor in her initial presentation. When she had the relapse, symptoms were abdominal pain and fever, which had not been present previously, and treatment with steroids did not improve her symptoms, laboratory studies, or physical examination. The colonoscopic findings showed a significantly different picture, as did the histopathology from the previous examination. The rise in titers of antibody to CMV demonstrated in this patient indicates recent systemic infection with CMV. This opportunistic CMV infection most likely occurred during the four-month period of steroid therapy, which may have suppressed her immune system.

Some patients with exacerbations of ulcerative colitis during corticosteroid therapy and found to have CMV cells in mucosal biopsy may improve clinically and histologically after corticosteroid withdrawal.[9] In our patient, however, symptoms did not improve significantly despite corticosteroid therapy withdrawal. The presence of the CMV cells in the biopsy specimens and the elevated serologic titers led to the initiation of intravenous antiviral chemotherapy, to which the patient responded favorably. A similar response was recently reported in a patient with a long history of ulcerative colitis.[10]

Our patient's course suggests that CMV colitis should be considered another cause of relapse of ulcerative colitis symptoms resistant to steroid therapy. This appears to be a case of CMV colitis in such a setting with documentation by histology and serology, as well as clinical, endoscopic, and histologic response to specific anti-CMV therapy.

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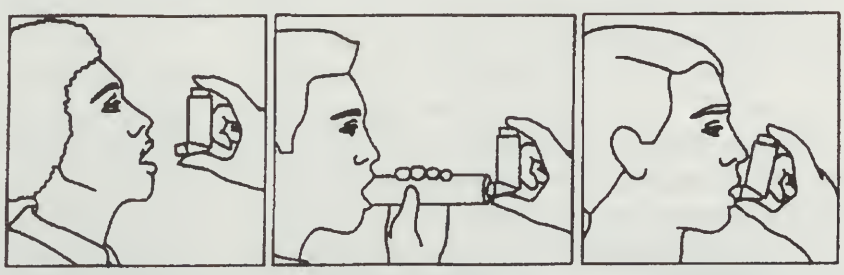
Geriatrics for the Clinician

INHALATION THERAPY AND THE ELDERLY: WHAT EVERY PHYSICIAN SHOULD CONSIDER

Chronic bronchitis and emphysema account for 3% to 4% of all deaths and rank among the leading causes of death in the United States[1]. In addition, prevalence, incidence, and mortality rates for these diseases increase with age[1]. Treatment with beta agonists, corticosteroids, and anticholinergic drugs constitutes the mainstay of modern management of these illnesses. Whenever possible, drug delivery via inhalation is the preferred method of treatment. Compared to systemic administration, inhalation may significantly reduce the occurrence of side effects without loss of efficacy.[2]

A recent survey indicated that Proventil and Ventolin metered dose inhalers (MDIs) were among the top 15 drugs dispensed (new and refill) by pharmacists in 1994.[3] Practitioners are apparently taking advantage of the efficacy and low toxicity in prescribing this form of therapy. It must be remembered, however, that even when optimal inhaler technique is used, less than 15% of the administered medication dose reaches the site of action.[4-8] MDIs are very difficult for most adults to use and require that special attention be paid to education.

To ensure adequate drug delivery, MDIs must be used properly (**Figure 1**). The technique does not seem very complicated, but it is actually quite difficult for many individuals, including a large proportion of elderly patients, to master. In one study of 101 elderly patients, 45% actuated the inhaler after the end of inspiration; 41% had breath hold less than 5 seconds; 30% had too rapid an inspiration, and 25% actuated the canister before inspiration.[9] Even with repeated education, only 55% of patients were able to master the proper technique of using MDIs two months after completion of a training program.[10] Without continual reinforcement, many patients will revert to improper technique.[11] Patients, however, are not alone in being unable to use MDIs properly. Several studies indicate a large proportion of health care providers (physicians, nurses, pharmacists) cannot perform the basic steps of MDI administration.[12-14] Health care providers' lack of proficiency in the



A. Open mouth with inhaler 1 to 2 inches away.

B. Use spacer (especially for young children).

C. In the mouth.

1. Remove the cap, inspect for foreign objects, and shake the inhaler.
2. Tilt head back slightly and breathe out to normal exhalation.
3. Position the inhaler (see diagram).
4. Press down on canister, releasing medication as you begin inhaling slowly (over about 5 seconds).
5. Hold breath for 10 seconds (or as long as comfortable).
6. Wait 1 to 3 minutes before taking additional puffs.

Figure 1. Correct technique for using an MDI

proper use of MDIs may contribute to their improper use by patients.[15]

Common problems

The most common problem in MDI use is the inability to coordinate actuation of the canister with inhalation (hand-lung coordination). Other common errors include inhaling too rapidly, forgetting to shake the inhaler, failing to hold the breath after administering the dose, and taking 2 puffs at a time rather than administering each puff separately. Elderly patients also may have problems with MDI administration as a result of arthritis, tremor, dementia, and poor eyesight.

Table 1. Devices available to improve MDI use

Device	Advantages	Disadvantages	Contact
Aerochamber	valved flow rate whistle minimal patient training available with mask	moderate size	Monaghan
ACE	valved flow rate whistle minimal patient training	moderate size	Center Laboratories
Azmacort	built in spacer	non-valved only available with triamcinolone	Rorer, Inc.
Inhal-Aid	minimal patient training	large and bulky	Key Pharmaceuticals
InspirEase	flow rate whistle collapsible minimal patient training	requires bag replacement non-valved	Key Pharmaceuticals
Ellipse	MDI can be stored inside small	non-valved	Allen & Hanburys
OptiHaler	minimal patient training	moderate size	HealthScan Products, Inc.
AutoHaler	breath actuated minimal patient training small	available only with pirbuterol	3M
VentEase			Glaxo
SpinHaler Dry Powder Inhaler	simple to use	difficult for patient with tremor	Fisons
RotaHaler Dry Powder Inhaler	simple to use	difficult for patient with tremor	Glaxo

Several available devices may help elderly patients use the MDI (**Table 1**). Spacers have been developed to increase the amount of medication reaching the lower airways and reduce the amount of medication deposited in the oropharynx.[16-17] A valved spacer can help patients who have difficulty coordinating canister actuation with inhalation. With inhaled corticosteroids, a spacer may increase efficacy while reducing the occurrence of dysphonia and oropharyngeal candidiasis. Spacers are available with masks for patients who are unable to wrap their lips around the MDI mouthpiece, including patients with tracheostomy.

A breath-actuated inhaler has been developed that triggers canister actuation and medication release when the patient inhales. It is currently available only with the beta-agonist pirbuterol. For patients who need a short-acting beta-agonist, are unable to coordinate actuation with inhalation, and are reluctant to use a spacer, the device would be beneficial.

Dry powder inhalers require the patient to insert a capsule containing medication into a small hole in the device, twist the device for medication release, and inhale the medication rapidly. Although these devices do not require the patient to coordinate MDI activation with inhalation, patients with tremor would find them difficult to use.

Some patients become noncompliant with their inhaled antiinflammatory agent regimen because they have not been given the necessary education. Patients may expect that inhaled antiinflammatory and anticholinergic medications will make them feel better as quickly as beta-agonist inhalers. Unless they are told otherwise, they may quickly become noncompliant when they fail to see any immediate benefits of treatment.

Myths and misconceptions

Drugs delivered via nebulizer do not necessarily work better than those delivered via MDI. Thus, a nebulizer should not be the first line delivery system in a patient unable to use an MDI. Spacers do not automatically increase medication delivery to the lungs. Medication delivered via MDI-spacer combination and medication delivered via MDI with optimal technique are equally effective.

The aerosol jet is delivered at approximately 60 miles per hour. Wrapping the lips around the MDI mouthpiece results in an increase in drug delivered to the mouth, but not to the lungs. Since only particles less than 5 microns in diameter are delivered to the lower airways, spacing the MDI mouthpiece about 2 centimeters from an open mouth allows inhalation of the suspended aerosol cloud. If a patient is unable to aim, however, the closed lips technique would be preferred.

Many patients believe that use of a spacer removes all concern about time delay between actuation and inhalation. In fact, because of gravity, the longer a patient waits to inhale through the spacer after actuation of the dose, the less medication gets delivered to the lungs.

Conclusion

The MDI is an efficient and effective delivery device when used properly. When prescribing medication to the elderly for pulmonary disorders, physicians should consider inhalation rather than systemic therapy whenever possible and assess whether a patient can use an MDI effectively. Physicians need to take an active role in educating their patients, observing patient technique and providing critique and reeducation on a regular basis. Some physicians may want to refer their patients to pharmacists who are willing to work with patients to provide teaching and reinforcement. Some patients are never able to use an MDI properly, however, and ancillary devices or other routes of delivery may need to be considered.

Tips for prescribing MDIs in the elderly

- Observe the patient's MDI technique at each encounter and correct specific problems.
- Do not expect patients to learn MDI technique quickly or to retain ability to use the inhaler properly.
- Demonstrate proper technique when teaching; if unable to do so, use a videotape or have another skilled individual demonstrate.
- Provide written instructional materials in large print with pictures.
- Teach patients which medications are to be used regularly and which should be used as needed for symptoms. Let the patient know what to expect.
- When patients have continuing problems with MDI technique, consider alternative devices (spacers, arthritis attachment, breath actuated device, dry powder inhaler).

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Acute hepatitis and renal failure following ingestion of raw gallbladders

In some cultures, eating gallbladders from certain species of snakes, birds, or fish is believed to improve health. A syndrome of acute hepatitis and renal failure following the ingestion of raw carp gallbladders has been described among people who live in Asia. Two cases of the syndrome have been reported in people who ate the raw bile and gallbladders of carp caught in Maryland.

In 1991, a 59-year-old man who had immigrated from Korea ate the raw gallbladder of a carp he had caught in a tributary of the Susquehanna River. Six hours later he developed diarrhea and abdominal pain. Three days later he was hospitalized with mild jaundice and persistent nausea and vomiting. Laboratory testing showed elevated levels of serum creatinine, total bilirubin, and transaminases. Renal ultrasound showed no evidence of hydronephrosis. There was transient progression of renal failure, but the patient was discharged from the hospital after six days.

The second patient, a 41-year old man who had immigrated from Cambodia, ate the raw gallbladders of three carp he had caught at a reservoir near Conowingo in October 1994. Two hours later, he developed transient right upper quadrant abdominal pain, nausea, vomiting, and diarrhea. Four days later he consulted his physician because of recurrent nausea, abdominal pain, and decreased urinary output. Laboratory findings were consistent with acute hepatitis and acute renal failure. The patient was hospitalized for hemodialysis the next day when his serum creatinine increased to 12.6 mg/dL. Renal and hepatic function improved gradually, and he was discharged 12 days later.

Two species of carp in the United States have been associated with bile-induced hepatitis and renal failure: the common carp and the grass carp. They can be caught without limit, and are an inexpensive food source used extensively by some populations.

The two cases of bile-induced hepatitis and renal failure described above suggest that clinicians should be aware of the eating habits and food exposures that may pose a risk for their patients. They also underscore the importance of obtaining careful food histories from patients, including those whose illnesses may not initially appear to be food related.

Source: *MMWR Morb Mortal Wkly Rep* 1995;44:565-566.

PERSPECTIVES

The growth and metamorphosis of Saint Joseph German Hospital

In 1798, when Baltimore was created by the union of Jones Falls, Fell's Point, and Baltimore Town, the total population was 26,000. The area had magnificent potential, however; it was a natural haven for ships and it was blessed with a mild climate and a good water supply that made it quite suitable for agriculture. Given certain home-rule powers by the legislature, the city had the opportunity to shape its own environment, and the urban area was soon differentiated from the country.[1-3]

The population doubled during the first decade, and soon only New York, Philadelphia, and Boston were larger. The Europeans who flowed into Baltimore initially were mainly of British descent and the Protestant faith. Few were Roman Catholics or non-British, except the German Lutherans who made up about six percent of the population.

A dramatic change in the population occurred when more than 53,000 newcomers poured into the port in the 1830s. Most of these individuals were Germans. The flood continued and was joined by a sudden influx of thousands of Roman Catholic Irish. The foreign-born were concentrated, with the heavily Roman Catholic wards being 8 and 12. The population numbered a little more than 212,000 in 1860 and reached 267,000 later in that decade.

The Germans exerted a profound effect on the growth and development of the city. In the three decades before the Civil War, about 200,000 German immigrants landed in Baltimore and many stayed. They retained their European customs with clubs, singing societies, and Turnvereins. German Catholic churches and schools were established to cater to this group, who spoke no other language.

Between 1840 and 1860, Baltimore became an industrial city with new manufacturers evolving into business specialists and exerting enormous socioeconomic power. The Baltimore and Ohio Railroad linked the water and overland trade routes. Technological momentum shifted as iron, coal, and steam transformed the city. From 1848 to 1852, 200 locomotives were built locally. Pianos, carriages, furniture, and clothing were manufactured. New homes were erected to house the growing multitude and bridges were made to provide access to these houses. Paralleling the growth of external transportation was that of the inner city; its horse cars, however, were but a feeble imitation of the steam railroads. Inner city lines connected the railroad stations and extended to the suburbs.

The health problems engendered by industrial changes became legion and were particularly bad during the hot weather. At one period, the board of health estimated that 50,000 horses were in the city. The streets became grimy and the Jones Falls, a sewer. Flood, drought, and poor water run-off led to well contamination and sickness beyond description. Typhoid fever, dysentery, scarlet fever, and smallpox were common. The stench about the Jones Falls and the inner harbor was horrible. Four serious floods occurred from 1858 to 1869 and severe droughts from 1866 to 1878. Not only was correction of the environmental factors necessary, but active therapy for the sick was imperative.

Improved living conditions led to a vast diminution of waterborne diseases. The acquisition of a good water supply and an adequate sewage system led to a reduction in the incidence of cholera, typhoid fever, and dysentery. Nevertheless, the existing hospitals were wholly inadequate to cope with the medical problems. The old Baltimore Infirmary (later the hospital of the University of Maryland), the Union Protestant Infirmary, and St. Agnes Hospital were earlier arrivals on the medical scene.

The need for a hospital in the northeastern part of the city apparently occurred to Catherine Eberhard early in 1864, when she indicated that she would donate three brick houses (numbers 187, 189, and 191), each three stories high, on North Caroline Street near Madison Street to be used as a hospital.[4-8] The thought was



Saint Joseph Hospital on North Caroline Street.

apparently communicated to the parish priest, who requested the Sisters of the Third Order of St. Francis in Philadelphia to provide regulatory and nursing functions for the proposed facility. The Reverend Mother Mary Agnes was invited to visit Baltimore to make the proper recommendations. She and Sister Aloysia came to the city on May 26, 1864. The following morning, they visited Father Kleineidam of St. Alphonsus parish, who favored the project. A second visit to Father Klauss of St. Michael's parish confirmed the thought of Father Kleineidam. The nuns found the location suitable, although the buildings would need repair and remodeling before they could be used for hospital purposes. Assuring them that funds could be obtained, Father Klauss advised the Sisters to return home and await the advent of the new archbishop, Martin J. Spalding. On July 31, 1864, he assumed leadership of the archdiocese, the oldest see in the United States.[9,10]

Encouraged, Mother Agnes returned to Philadelphia and in September was asked to come back to Baltimore. Parish enthusiasm had not abated, and Father Klauss actively sought funds to consummate the project. Two short Latin notes in the Acta Episcopalia indicate that Archbishop Spalding approved. The first, dated August 27, 1864, stated: "I agree to approve at the request of Rev. D. Kleineidam, C.S.S.R., that the Franciscan Sisters, established in Philadelphia, should come to Baltimore to work among the Germans—by establishing a school in the home of a pious German woman near to the Church of St. James."[11] Another note dated May 5, 1867, stated: "I gave permission to 'Mother' Mary Agnes O.S.F. Mullin, of the Sisters from Philadelphia, to start a hospital in this city."[12]

Mother Agnes sent Sisters Clara, Crescentia, and Scholastica to assume charge. Sister Clara was appointed superioress. The facility, known as the Saint Joseph German Hospital, was used until demands for more space necessitated the purchase of additional property nearby. A temporary building was erected, and in 1871, ground was broken for the new building.

In 1880, additional revenue accrued when the hospital concluded arrangements with the Marine Hospital Department of the United States to care for all sick sailors entering the port of Baltimore. The charge for complete service was seventy cents per day for each patient, of whom 386 were admitted during the first year. The contract continued until 1887, when the Marine Hospital was built.

In 1901, a wing was added for the school of nursing. In the big fire of 1904, patients from City Hospital were

Born in Baltimore in 1843, Oscar Coskery received a doctor of medicine degree from the University of Maryland School of Medicine in 1865. He was an assistant surgeon with the United States Army for a short period and then physician to Saint Joseph German Hospital from 1870 to 1882. He was president of the staff from 1870 to 1880. He also served as professor of surgery at the College of Physicians and Surgeons in Baltimore in 1872 and again from 1879 to 1889.

Among others, the consulting staff at Saint Joseph German Hospital included Dr. Nathan R. Smith, the famous professor of surgery at the University of Maryland medical school. Active staff included Drs. S.C. Chew, F.E. Chatard, Jr., G.L. Robinson, and S.E. Atkinson. In December 1872, Dr. Henry C. McSherry was appointed the first resident physician. Educated at Loyola College, he obtained his medical degree at Maryland in 1872. He subsequently became interested in eye, ear, and throat problems and had teaching posts at Maryland and the Polyclinic and Postgraduate Medical School. A long line of interns and residents followed. Eventually, board-accredited residencies were in place in medicine, surgery, and gynecology and obstetrics. In later years, as requirement changes occurred, they were discontinued.

transferred to Saint Joseph. After a number of trips by ambulance, all the City patients were safely placed and given care. In 1918, the hospital's name was changed to Saint Joseph Hospital because of anti-German sentiment at the close of World War I. (At this time, German Street also became Redwood Street.)

In 1944, knowing the hospital was aging, the Sisters purchased 52 acres on Loch Raven Boulevard to build a new structure, but later sold the land to the diocese. In 1956, the administration of the 250-bed institution



A Sister discharges a patient from the old hospital.

was advised that full licensure by the Maryland State Department of Health could not be granted because of nonconformity with fire regulations. A provisional license, however, was granted.[13,14] The precarious state of the hospital was well known to the staff. It recommended that the physical structure be rehabilitated to achieve conformity with hospital standards and building codes; that the bed capacity be reduced from 250 to 175; and that a new hospital be built at some time in the future. In May, Sister Pierre, O.S.F., was sent from Trenton to be the administrator and to arrange for the hospital's closing. She said the immediate physical condition of the building prevented it's being used safely and that renovation would cost more than building a new hospital.

A committee to preserve the hospital was formed. Consisting of Drs. Harry Connolly, Joseph Krejci, and Otto C. Brantigan as the chairperson, its task was to find an answer to the problems besetting the institution. At its first meeting, on June 14, the committee concluded that the capacity of the hospital should be maintained, the nursing school should not be closed, the physical plant

should be renovated, and plans for a new hospital should be formulated.

On June 15, Sister Mary Leandro, the Superior General, advised Sister Pierre that the hospital had to be closed. Communicating her fears to Dr. Brantigan, Sister Pierre reported that the hospital had not been licensed for two years and it presented a fire hazard beyond remedy. Dr. Brantigan assured her that the medical staff would help to alleviate conditions if the community of Sisters wished to keep the hospital open. The institution's low morale was lifted somewhat by declarations of support from components of its infrastructure.

The problem of the nursing school again reopened. Mother Leandro told Sister Pierre that the decision about the school remained local. Sister Pierre decided that the school should remain open.

The building underwent another inspection and being assured that changes would be made, the inspectors issued a temporary license. When the extant fire hazards were removed, the Maryland State Board of Health announced that the hospital's license had been renewed.

Although this period had been one of intense stress, the Sisters, medical staff, and friends of the hospital had found an alternative to closure. Particularly to be remembered was the Ford Foundation, which contributed $122,400 for repairs. With the modernization of the structure completed, plans for a new hospital were formulated, and in 1958, negotiations were concluded for the purchase of the Turnbull estate in Towson as a site for the new hospital. Three other sites had been considered: Eudowood; an area near St. Vincent's Orphanage on York Road; and the property on Loch Raven Boulevard formerly owned by the hospital then sold to the diocese (Good Samaritan Hospital is now located there).



Otto C. Brantigan, M.D.
Photo by Fabian Bachrach

Otto C. Brantigan, M.D. was educated at Northwestern University, where he received his bachelor of science degree in 1931, his bachelor of medicine degree in 1933, and his doctor of medicine degree in 1934. He then served an internship and surgical residency at the Baltimore City Hospital. Practicing general and thoracic surgery, he nevertheless found time in a busy schedule to teach. He was a man of intense patience and industry, enamored of medicine and surgery, courteous, courageous, and public spirited in all his medical relationships. Described as "professorial," he was always well prepared for his teaching sessions. He wrote 111 published scientific articles (Brantigan CO, personal communication) and a textbook of clinical anatomy.[5]

In 1959, he reported on the treatment of emphysema by reduction pneumoplasty.[16] Although the technique was not generally used because of inherent complications and objections by other thoracic surgeons, the operative procedure has recently been revived and Dr. Brantigan's initial reports substantiated.[17-19] Reduction pneumoplasty may still be regarded as a procedure not widely tested, but the door to further investigation and patient benefit has been reopened.

Dr. Brantigan was chief of surgery at Saint Joseph Hospital in 1957, and president of the medical staff in 1959 and 1960. In 1961, he worked to secure accreditation of a four year surgical program at the hospital. The Otto C. Brantigan Medical Library perpetuates his name at Saint Joseph Hospital. In addition, an operating suite is named for him and two other physicians on the preservation board.



The new hospital in Towson.



Sister Mary Pierre O'Regan.

Ground breaking occurred in March 1963 and the hospital was first used in November 1965. Its name was later changed to Saint Joseph Hospital, Incorporated, and then to Saint Joseph Medical Center. The new campus offered considerable room for expansion, and the usual hospital offerings were later enhanced by the addition of more sophisticated services.

Possibly the only program of its kind in the world, the International Center for Skeletal Dysplasia, which gives specialized care to "little people," opened in 1986. In addition to medical and surgical treatment, the facilities include a specially designed physical therapy room and pool.

The Retina Institute of Maryland, which opened in 1988, is widely recognized for its research in retinal and vitreous disorders. It also provides comprehensive medical and surgical management of the usual and unusual diseases of the retina.

In 1995, the Heart Institute was created to enhance the existing cardiac care area. Telemetry units, a chest pain center, and a cardiovascular fitness program supplement the basic cardiac services.

The Sisters of St. Francis have exerted a dominant effect on the healing mission of the hospital for many years. Nineteen Sisters have guided the hospital as president. One of the more remarkable is Sister Mary Pierre O'Regan, who served as president for 27 years during two tours of duty. She was the administrator from 1939 to 1947, when she went to Trenton to help build St. Francis Hospital. Returning to Baltimore in 1956, she saw Saint Joseph Hospital through its crisis and subsequent building program in Towson. In 1972, she was honored as the Woman of the Year by the Towsontowne Business and Professional Women's Clubs. Later, Sister Pierre was named Citizen of the Year by the Archbishop Keough Council of the Knights of Columbus.



Sister Marie Cecilia Irwin.

Sister Marie Cecilia Irwin headed the institution for 19 years and saw, among other things, the creation of the Bautz Diagnostic Wing and the inauguration of heart surgery at the hospital. In a burgeoning community, she witnessed the growth of the hospital from 300 to 460 beds. New services and buildings were required as a result of technologic advances in diagnostic work and the creation of noninvasive surgical procedures. Sister Irwin has received many honors for her leadership and contributions to health care, including the Andrew White medal for distinguished Marylanders and a papal medal, the Pro Ecclesia Pontifica award. The conclusion of her term in office in 1994 saw the transfer of much of the hospital's administrative work from the Sisters to a dedicated lay staff.

In its 131st year, Saint Joseph Medical Center has achieved the medical maturity envisioned at its resurrection 40 years ago. Its staff exemplifies what Isaac Newton wrote to Robert Hooke in 1676: "If I have seen further, it is by standing on the shoulders of giants." The present members reside upon a solid foundation of past sincere and earnest workers. The future of the institution appears as promising as its past.

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1955:

- *The Brooklyn Dodgers beat the New York Yankees to win the World Series*
- *Vladimir Nabokov publishes* Lolita
- *The United States Air Force Academy opens*
- *Atomic power is first used commercially in Schenectady, New York*

Nurse Recruitment in Maryland

Excerpted from the *Maryland State Medical Journal* 1955;4:50–51

Anne Miller, R.N., A.B., M.N.
Ms. Miller was chairman of the Careers Committee of the Maryland League for Nursing.

In the past fifteen years, the shortage of nurses throughout the United States has become increasingly acute. Although the number of nurses engaged in nursing is constantly increasing, and the numbers of students admitted to schools of nursing remain constant, the field itself has expanded so much that it is almost impossible to keep up with it. This expansion is due to many factors: the actual number of hospital beds has increased; voluntary insurance plans have made it possible for many more people to come to hospitals; early ambulation has shortened the length of hospital stay. In addition, public health nursing, industrial nursing and other specialties have made the need for nurses even greater. The problem facing all of us in the health field is to attract more young women into the profession.

Here in Maryland, a very active program has been under way for some time. The Careers Committee of the Maryland State Nurses Association, in cooperation with the Women's Auxiliary to the Baltimore City Medical Society and the Maryland Society for Medical Research, Inc., produced a recruitment film "Girl With A Lamp" which is available now. Each individual school in Maryland has its own recruiting program and sends

speakers and material to high schools. Another form of recruitment was devised by the Women's Auxiliary to the Medical and Chirurgical Faculty.

The Future Nurses Clubs have proved invaluable, not only in stimulating interest in nursing, but in all health activities through the communities. Members of the clubs make tours to hospitals, serve on community health drives (Cancer Fund, Christmas seal fund, etc.), and some have collected clothing for Korea and eyeglasses for the Frontier Nursing Service. Many of the girls work in hospitals in the evenings and over weekends. Some spend their summer vacations in pre-nursing aide courses. Some have taken courses in home nursing. All of the clubs, at one time or another, have put on exhibits on nursing in their schools and communities. These activities bring positive results—one club sent thirteen students into basic nurses' training, another sent seventeen. The Women's Auxiliary to the Medical and Chirurgical Faculty and the Careers Committee of the Maryland League for Nursing work very closely together.

In October of this year the first National Nurse Week was proclaimed. Governor McKeldin issued a proclamation, editorials appeared in the newspapers all over Maryland, and there were radio and television programs. The Future Nurses Clubs had posters and exhibits in schools and local stores.

As a result of the combined efforts of many people, the enrollment of students in nursing schools has climbed steadily. In 1953, 739 students were admitted to 23 schools. In September 1954, 853 were admitted. Much of this is due to the intensive efforts of the nursing schools, which have given generously of their time and personnel to visit the high schools, and to entertain the high school girls when they visit the hospitals. There is still a wide area to cover. We hope to see the formation of Future Nurses Clubs in parochial and private schools during the coming year. Those of us who have worked in this program, feel that it is well worth any time or effort it involves. Not only are we introducing students to a most rewarding profession, we ourselves are learning a great deal about the communities in which we live. ■

Commentary

It was a warm summer evening at the end of a very rewarding day as a nurse of 35 years when I relaxed on my patio with a glass of iced tea to read the article "Nurse Recruitment in Maryland." As I read on, I wasn't reading news—I had lived those days when there was a shortage of nurses. How quickly circumstances change. "Girl With A Lamp" is probably outdated.

As I ponder the facts in this article, I wonder how this article would read in 1995. The author might sound a bit less enthusiastic. Of course, there would be no gender bias.

We are faced today with many more options for registered nurses than 40 years ago. However, we have more nurses today than we have employment opportunities.

We still have the privilege of a variety of schools of nursing in Maryland. The dilemma is with the changes in health care and the decreased length of stay in hospitals mandated by insurance companies. The job market for registered nurses in a hospital setting is decreasing and most other agencies want a year's experience before hiring.

The question is, where will our graduates of these fine institutions work? Will we be faced with an ethical issue in continuing to admit and graduate nurses when the job market is compromised?

Ann Kennedy, B.S.N., R.N.C.

Ms. Kennedy is a psychiatry liaison nurse at St. Joseph Hospital in Towson and a clinical instructor at The Johns Hopkins Hospital School of Nursing. ■

Uncertain Times: Preventing Illness, Promoting Wellness

1996 International Conference on Physician Health

Sponsored by the American Medical Association, the Canadian Medical Association, the Federation of State Medical Boards, the Federation of Medical Licensing Authorities of Canada, the Federation of State Physician Health Programs

February 7-10, 1996

In cooperation with the American Society of Addiction Medicine and the Society for Professional Well-Being

Sheraton San Marcos Hotel Chandler, Arizona

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In these times of uncertain economic forces and rapidly advancing scientific knowledge, the stresses of keeping one's practice current and financially viable exact their toll on physicians. Physician health now includes a broad, pro-active, preventive approach of reducing all types of physician health problems and offering assistance before there is actual impairment.

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Key Note Speakers will include:

Frances Conley, MD -	"Ruminations of an Academic Maverick"
Leah Dickstein, MD -	"Preparing Our Trainees for Healthy Living"
Ronald Shellow, MD -	"Diagnosis vs. Disability: Legal and Clinical Issues"

Pre-Conference Institutes will include:

Update on Chemical Dependency: Edward Senay, MD, - *Cocaine;* Robert Swift, MD, PhD - *Current Pharmacologic Management Strategies;* Norman Miller, MD, - *Assessment and Management of Dual Diagnosis*

Update on Psychiatry: Morton Silverman, MD, - *Suicide;* Dominic Ciraulo, MD - *Newer Antidepressant Drugs and Drug Strategies;* Eberhardt Uhlenhuth, MD - *Anxiety Disorders: Changes in Diagnoses and Management*

Women's Health, 1996: Erica Frank, MD, MPH - *Research Needs and Plans;* Carol Scott, MD, MPH - *Violence as a Healthcare Issue;* Michael F. Myers, MD - *Relationships and Other Mental Health Issues*

Recreation
When not discussing physician health issues, promote your own personal health. You will find an 18-hole championship golf course, several swimming pools, and tennis courts – two lit for night play. Enjoy jogging around the golf course, bicycling in the balmy southwestern breeze, horseback riding on the edge of town or working out at the nearby fitness center.

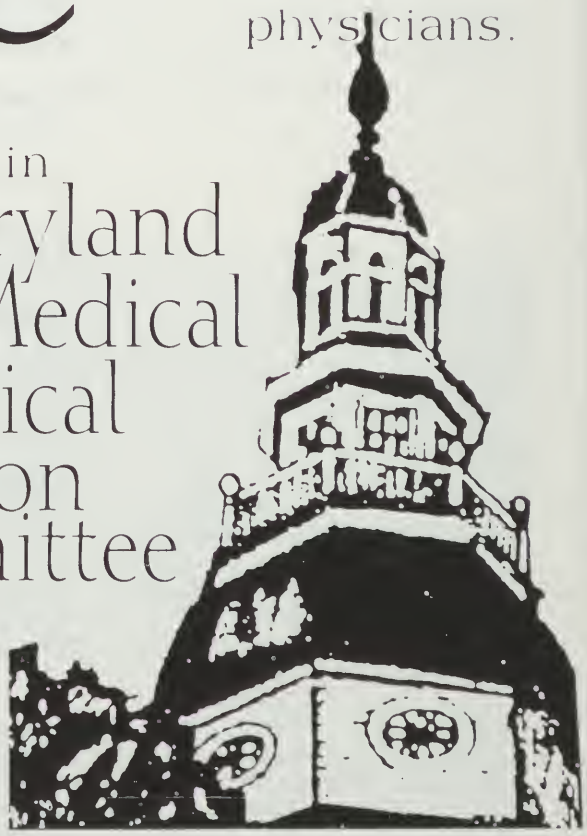
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Alliance

The First Maryland Leadership Confluence

When I became president-elect of the Alliance to the Frederick County Medical Society nine years ago, I attended my first Leadership Confluence meeting, a twice yearly training session lasting three days, sponsored and conducted by the AMA Alliance in Chicago. I was a newly elected officer of my county Alliance and woefully ignorant of the organization and goals of the state Alliance, and even more so, those of our national organization. The confluence was a revelation to me—I learned so much about our nationwide organization and the roles that the component county and state Alliances play in the overall picture. More importantly, I began to acquire some knowledge of how to lead a group and conduct a meeting. I began to believe that I, too, could handle the duties of the office to which I was to succeed the following year. I met many other ladies who were at the same learning level as myself, and by sharing our fears and misgivings with each other, we began to acquire confidence in ourselves. Over the subsequent years, I attended a number of other confluences, each time learning something new and valuable.

Attendance at the national confluence meetings is unfortunately limited by a formula based on the number of Alliance members in each state. Maryland, with approximately 1,200 members, is limited to sending only six members each year. Therefore, every county president and president-elect is not able to attend. When I became president-elect of our state Alliance, I decided that one of the most useful things I could do for our organization as president would be to bring a similar opportunity for learning leadership techniques to all of our county officers as well as any other members of our state Alliance who wanted to learn. I broached the idea to the Executive Board and received their enthusiastic support as well as permission to allot a portion of our Alliance's budget to fund the meeting. It was felt that the meeting should be held as soon as possible following the beginning of the new fiscal year so the newly elected officers would have the benefit of the educational experience soon after taking office.

Accordingly, September 13, 1995, was chosen as the earliest date practical to schedule the event and still allow time for publicizing it to the component county Alliances



Mildred Taylor, SMAA past president



Helen Boyer, Alliance parliamentarian



Diane Chow, AMAA national field director



Caramine Holcomb, AMAA national field director

and to those of our neighboring states. Recognizing that most of the attendees would be busy with careers or have young children at home, it was decided that the workshop would be confined to one day, beginning with talks by four speakers, two from our own Alliance and two from the national Alliance. Following the didactic portion, there would be an informal question and answer period, then lunch. The meeting, including lunch, would be free of charge to Maryland members and those from out of state would be charged a nominal sum.

The workshop began with eye-opening coffee and pastries at 8:00 A.M. and opening remarks by J. Richard Lilly, M.D., president of Med Chi. Dr. Lilly was introduced by Mr. Angelo Troisi, chief executive officer of Med Chi. Both gentlemen were generous in their praise of the work of the Alliance and of our efforts to inaugurate a new educational experience for our members. We thank them for taking time from their busy schedules to be with us.

At 9:00 A.M., our first speaker, Mildred Taylor, began her talk on the "Art of Leadership." Mildred drew from her vast experience as president, both of her own Alliance and of the Southern Medical Association Auxiliary, to put together a most informative talk, complete with suggested references to read. She was followed at 9:45 by Helen Boyer, past president of the Alliance and Alliance parliamentarian, who admirably met the challenge of enlivening an otherwise dry subject by demonstrating how proper parliamentary procedure can make a meeting go smoothly.

After a 30-minute coffee break, the first of our speakers from the AMAA, Diane Chow, national field director, spoke on a topic vital to the strengthening of our organization, "Membership Development." She brought forth many ideas on how to make membership in the Alliance attractive to our young colleagues. The final speaker was national field director Caramine Holcomb, who spoke on the all-important subject of our only purely fund-raising activity, the AMA-ERF. She detailed many of the ways that have been so successfully used to raise money for this worthy cause and how the money has been put to good use by the AMA.

A 30-minute question and answer period followed the last speaker, during which the panel of experts fielded questions from the audience and elaborated on points of interest. We then adjourned for a delicious lunch, during which each participant was presented with a certificate of attendance as a remembrance of this first Maryland Leadership Confluence Workshop. Final adjournment of the workshop at about 3:00 P.M. allowed the participants time to beat the rush hour traffic out of the city.

The attendees were asked to fill out an evaluation form that had been distributed so that we might get some idea of how useful the workshop had been as well as provide help in planning future "mini confluences." Out of the 45 participants, 42 forms were returned and there was unanimous approval of the form and content of our first workshop. Almost 100% rated *all* the speakers as excellent and everyone agreed that they had benefited from the meeting. There was overwhelming sentiment for making the workshop an annual event and we received many suggestions as to other topics to cover. The out-of-state participants from New Jersey, Virginia, West Virginia, and the District of Columbia were most happy that we had extended invitations to our neighboring states and many felt that the confluence should become an annual session for the whole mid-Atlantic region, perhaps hosted by other states on a rotating basis. I am happy to report that the Alliance House of Delegates, at its fall meeting on October 18, approved the establishment of the Maryland Leadership Confluence Workshop as an annual event and there will be a standing committee formed to implement this decision.

In conclusion, I want to thank all of those Alliance members who contributed their time and efforts in the planning and presentation of our first Maryland Leadership Confluence. In particular, I want to thank the four speakers who so generously donated their time and expertise.

MEHRY M. REID
Alliance president ■

A long-time member-at-large of the Alliance to the Medical and Chirurgical Faculty of Maryland and supporter of the AMA-ERF from the Eastern Shore, Diane Bisanar, has won the 50/50 lottery. A total of $1050 was raised by the 50/50 project this year, making the winner's share $525. Dr. Leslie Miles won the consolation prize.

ELIZABETH LINHARDT

Minutes of the Meeting of the House of Delegates
Friday, September 8, 1995

▼ ***Delegates/guests present***

A list of the delegates and guests present is on file in the executive office of Med Chi.

▼ ***Call to order***

The meeting was called to order at 1:20 p.m. by Allan D. Jensen, M.D., speaker of the House of Delegates, in the Palmetto Conference Rooms at the Princess Royale Conference Center and Hotel in Ocean City, Maryland.

▼ ***Invocation and Pledge of Allegiance***

The House stood for the invocation by The Reverend Merle Fisher, First Presbyterian Church, Ocean City, and the playing of the national anthem.

▼ ***Credentials Committee report***

James Chesley, M.D., chairperson of the Credentials Committee, reported that a quorum was present.

▼ ***Introduction of guests***

Guests introduced were Paul Markowski and Fred Humphries of the American Medical Association, and Raymond Yow, chairman of Medical Mutual. Dale Adkins, Esq., was presented as the parliamentarian.

▼ ***Approval of minutes***

The speaker asked, with the exception of typographical errors, if were there any corrections to the minutes. The minutes of the July 15, 1995 meeting were approved.

▼ ***Awards***

- **Media awards**

  Melvin Rapelyea, M.D., chairperson of the Public Relations Committee, presented the awards for Med Chi's Tenth Annual Media Awards Program for excellence in medical journalism and noted that the first-place winners would have a donation made in their name to the charity of their choice.

  Lisa Willis, WBFF-TV, Baltimore, won first place in the video category for the two-part series, "Matter of the Heart," which dealt with angioplasty and its benefits for heart patients. Ms. Willis designated the Easter Seal Society to receive the donation. Bill Seiler, WMAR-TV, Baltimore, won second place for "Scoliosis Recovery," which followed the progress of a young woman after her surgery for scoliosis.

  Lynne Salisbury, *Howard County Times*, won first place in the nondaily newspaper category for "Healing the Scars Within," which told about the Mid-Atlantic Burn Camp in Lacey Spring, Virginia. Ms. Salisbury designated the Mid-Atlantic Burn Camp to receive the donation. Diane Brown, *Columbia Times*, won second place for "One Man's Struggle," which described a man's fight against multiple sclerosis and his constant efforts to maintain his independent lifestyle.

  Dr. David Brown and Kathleen Day, *Washington Post*, won first place in the daily newspaper category for the two-part article, "The Abuse of Antibiotics," which provided an in-depth analysis of how bacteria are winning the war against antibiotics. Linell Smith, *The Sun*, won second place for "Prostate Health."

  John Stupak, Consultation Radio Network, won first place in the radio category for "Menopause." Mr. Stupak designated the Baltimore Wellness to receive the donation.

- ***Maryland Medical Journal* award**

  John W. Buckley, M.D., editor, *Maryland Medical Journal*, reported that the editorial board selected the article "Hospice: the most important thing you didn't learn in medical school" by F. Michael Gloth, III, M.D., as the winner of the 1994 best article award, which appeared in the June 1994 issue of the *Maryland Medical Journal*.

- **Henry Laughlin, M.D., award**

  Dr. Buckley noted that a plaque was being sent to Dr. Henry Laughlin to honor him for his participation over many years as a member of the editorial board of the *Maryland Medical Journal*.

▼ ***Emeritus membership***

Treasurer Carol W. Garvey, M.D., asked that the House dispense with the reading of the list of emeritus members since members were sent a list. A motion was made and approved

to dispense with the reading of the list and the names were approved as emeritus members.

▼ *Keynote speaker*

Joseph Fastow, M.D., introduced the keynote speaker, Virginia Thomas, director of community and intergovernmental relations, University of Maryland, Baltimore Campus, and a former member of the Maryland House of Delegates, who gave an update of the 1115 Waiver, followed by a question and answer period.

▼ *Report of the speaker of the house*

The speaker thanked staff and members of the Reference and Credentials committees for volunteering for this meeting. It was noted that although attendance appeared to be down at this House of Delegates meeting, it was the first time CME was being run simultaneously with the House meeting. The Committee on Scientific Affairs was congratulated along with James Flynn, M.D., chairperson of that committee, and Joan Mannion, staff to the committee, for putting together an outstanding, comprehensive meeting. It was noted that 335 people preregistered for this meeting, which was more than in the past.

The House was asked to attend three meetings over the next two days: the Reference Committee meetings on Saturday, the plenary session, and the meeting being held by First Options Health Plan. The various subjects to be discussed at reference committees were noted.

Dr. Jensen pointed out that Richard Corlin, M.D., speaker of the American Medical Association House of Delegates, would be the guest speaker for the plenary session in which primary and specialty care in the 21st century would be discussed. The AMA proposal for changing the Medicare system was also discussed, along with the speaker's concerns about the recommendations. It was recommended that everyone read the document and attend the plenary session to ask Dr. Corlin about the document. It was noted that the recommendation was discussed at the last Board of Trustees meeting, at which time no action was taken.

The speaker noted that both Maryland Physicians, Inc. (MPI) and First Option Health Plan (FHOP) would be making a presentation about Med Chi's managed care initiative. He explained that the House of Delegates directed Med Chi two years ago to create an IPA of some sort. It was felt that Maryland Physicians, Inc., was close to a final proposal, which is to work in cooperation with First Options Health Plan and in partnership with hospitals. He acknowledged that this was a totally different concept than the House of Delegates discussed two years ago, but it may be the only viable approach. He noted that at the last Board of Trustees meeting, the board allowed MPI to continue discussion with FOHP, but required MPI to report back to the trustees for approval of any action.

The speaker concluded by noting that it was important that delegates report back to the members of their component societies and get their input.

▼ *President's report*

The president began by updating the House on Med Chi's communication system. The ability to communicate with the senior staff has been upgraded to a point that Dr. Lilly was reached while out of state by senior staff members and was able to reach the CEO the next day using cellular phones. Dr. Lilly urged members to use the communication system. E-mail will be installed shortly at Med Chi.

The president noted that the new Board of Trustees, modeled after the AMA, has displayed a great deal of cooperation and enthusiasm and that Med Chi was now giving better representation to its "sister societies."

- Resolutions forwarded to the Board of Trustees and action taken:
  20-95 Med Chi IPA—An update on the IPA, mandated by this resolution, was on the agenda for this meeting by Lawrence Pinkner, M.D., chairperson of the IPA board of directors.
- 26-95 AMA Sponsored Universal Health Care Plan—All state medical societies have been contacted to cosponsor this resolution and many have indicated they would support this concept. This resolution will be forwarded to the AMA for consideration during the December 1995 AMA meeting.
- 27-95 Access to Quality Health Care—This resolution was forwarded to the Council on Legislation and the Council on Medical Services for action.
- 30-95 Support of Mental Health Care Providers—This resolution was referred to the Council on Medical Services and the Council on Legislation.

Dr. Lilly noted that the staff has mounted a major effort to increase membership, and Med Chi has reached a goal of 111% growth. Maryland will probably show the largest increase in the AMA Federation.

Dr. Lilly said a new program being considered by the AMA is Physician Sponsored Coordinated Care (PSCO). The AMA legal staff has been contacted to obtain more information. Basically, the AMA plan would allow for direct contracting with physician-run networks.

Dr. Lilly invited all physicians to attend the AMA Reference Committee meetings on December 3 and 4, 1995, which will be held in Washington, DC. Also at that meeting, Roland Smoot, M.D., will be honored at a dinner.

Dr. Lilly concluded by noting that he was honored to be a physician and Med Chi president and looked forward to doing his best during the year for the members.

▼ ***Chief executive officer's report***

Mr. Troisi noted that the Medicare issue in the federal budget is a very important concern that will affect all citizens and that the AMA booklet "Transforming Medicare" was available for distribution. A compilation of news articles depicting what patients are being told about medicine had been prepared for dissemination because it is important for physicians to know what their patients are being told.

▼ ***IPA update***

Dr. Jensen introduced Dr. Larry Pinkner, chairperson of Maryland Physicians, Inc. (MPI), and noted that on August 17, 1995, the Board of Trustees voted to allow MPI to sign a memorandum of understanding with First Option Health Plan of New Jersey (FOHP) that clearly stated that MPI may continue defining the necessary steps to form First Option Health Plan of Maryland, but that MPI must come back to the Board of Trustees for approval. He named the board of directors of MPI. He also noted that First Option Health Plan of New Jersey would give a formal presentation on Saturday.

Dr. Pinkner reported on the efforts of MPI during the past several months to identify a type of organization that could be developed to satisfy the House of Delegates mandate for a statewide physician-run IPA. He explained the financial and other requirements that would be necessary, which he believed to be unattainable and which in his opinion make an IPA not a viable option in Maryland. He explained the reasons why the MPI board of directors had recommended that Med Chi enter into a relationship with First Option Health Plan of New Jersey. Dr. Pinkner then gave details about the proposed organization.

- The board of directors would consist of physicians and hospitals in equal numbers, a 50-50 governance.
- Membership would be open to all Maryland-licensed physicians, without a requirement to purchase stock.
- Not all hospitals would be invited to join, even though they are eligible.
- Hospitals would select their representatives, and physician staffs of member hospitals would elect their representatives to the board of directors.
- Shares would be available to member hospitals and to member physicians. Purchase of equal numbers of shares would give physicians and hospitals equal representation in the company. The shares offered would be in a New Jersey company and designated for the Maryland corporation.
- Med Chi would have veto power over the sale of the company.

Many of the delegates asked questions about the proposed organization. Dr. Jensen reminded the House that no action would take place until the House of Delegates meeting on September 10, after the formal presentation by FOHP.

Some of the questions or comments (and in some instances, responses by Dr. Pinkner) were as follows. What will happen when physician members find out that the hospitals where they have privileges are not a part of the network? Had MPI considered the managed care organization proposed by Medical Mutual? The joint physician-hospital organization was not thought to be consistent with Resolution 20-95 adopted by the House of Delegates on May 6, 1995. (Dr. Pinkner pointed out that a physician-owned insurance company does not provide care and is different from an independent practice association.) A delegate reported that some physicians in Prince Georges County have formed a single-specialty IPA, with organizational and financial help from the AMA. Several delegates described large physician-owned IPAs which are negotiating successfully with hospitals. (Dr. Pinkner noted that hospitals are going to have some say in health care.)

A delegate pointed out that FOHP had not been endorsed by the New Jersey Medical Society. Another delegate noted that when Resolution 20-95 was passed, the initiative was expected to include a special benefit for Med Chi members, but this had not been described. (Dr. Pinkner said that the issue was being addressed, and also the issue of the position of the Med Chi Insurance Agency.) What happened to the $500 contribution by many physicians? (MPI could not reveal its

consultations and deliberations because of SEC limitations.) A delegate reported that some hospitals had claimed that Med Chi supports FOHP, which had not been approved. Can the Med Chi Board of Trustees approve an action relating to FOHP, or must the issue be brought to the House of Delegates? Another delegate responded that the House can instruct the Board of Trustees. A delegate commented that if Med Chi members want a physician-owned organization, they will have to put up a lot of money.

▼ ***Treasurer's report***

Carol W. Garvey, M.D., treasurer, noted that a preliminary budget had been distributed. She noted that it looked as if Med Chi anticipated a deficit even though it did not. She noted that it was written that way because Med Chi has money for contingencies and capitalization of equipment and was conservative about revenue. She noted that a dues increase was not anticipated in 1996. Expenditures in 1995 included a state-of-the-art copier, which has saved money by having most copy work done in-house; a new sound system; and improvements in the Annapolis building. The 1994 audits have been completed and will be presented in January to the House of Delegates. Dr. Garvey also noted that the criminal case against the former assistant controller is not settled, but that it appeared that complete restitution will be made.

▼ ***Annual council reports for 1994-1995***

Paul A. Stagg, M.D., secretary, noted that the annual council reports were in the August 1995 issue of *Maryland Medical Journal* and moved to dispense with the reading of the reports. The House approved.

▼ ***Reports of council chairpersons***

- **Council on Bylaws: J. Ramsay Farah, M.D.**
  - Reviewed the rules and bylaws of Med Chi, and submitted seven bylaws amendments to Reference Committee B for consideration.
  - Reviewed the Report 1-95 of the Council on Planning and Development "Submission of Resolutions to the AMA House of Delegates," and submitted a rule regarding this matter.
  - Drafted a rule regarding BPQA nominations.
  - Council had been revising the Compendiums of Medical Ethics and Medical Practice.

Dr. Farah called on Emidio Bianco, M.D., chairperson of the Rules Committee, who listed the rules that had been approved by the Board of Trustees. Dr. Bianco noted that under the present bylaws, rules necessary for the conduct of the work of Med Chi "shall be adopted and amended as necessary by the Board of Trustees. . .and presented to the House of Delegates at its next meeting and shall become final if no action is taken by the House."

- 5.4.1 Procedures for the Selection of BPQA Candidates for Submission to the Governor.
- 5.1.0 Resolutions Submitted by AMA's House of Delegates.
- 5.9 Med Chi specialty societies, regarding submission of membership rosters each year to determine delegate representation.
- 5.2 Resolutions, regarding late resolutions being submitted to Med Chi for formatting and assignment to reference committee.
- 5.3 Reference Committee, amended to allow a smaller number of delegates to staff a reference committee.
- 5.3.1 Reference Committee, allowed reference committees to invite other individuals to attend hearings for the executive sessions.
- Rule 5.8 was referred back to the Rules Committee for clarification.

Dr. Jensen noted that the rules that were distributed would not be discussed by a reference committee. The House will be asked whether it wishes to adopt the report at the next meeting of the House.

- **Council on Medical Education: James Flynn, M.D., for Henry Wagner, M.D., chairperson**

  Scientific Activity Committee

  - The agenda for the semiannual meeting has been expanded.
  - The committee is also currently preparing for the 1996 Annual Meeting and requested input for topic and format.
  - On September 20, a half-day CME program on capitation would be held at Med Chi.
  - At the end of September at Prince George's County Hospital, a program on computerized medical record keeping would be held.

- The second module of the Maryland Physicians' Campaign Against Family Violence, a self-study guide on child abuse, would be available fairly soon.
- On Saturday, October 21, the sixth Annual Drug Abuse Conference would be held in Osler Hall.

Continuing Medical Education Committee

- Reviewed the CME status of 12 hospitals.
- Accredited one new hospital.

Specialist Identification

- Considered 53 applications since June and approved 48.

Maryland Medical Journal *editorial board*

- The House was asked to focus on two special issues of the journal: smoking and youth, and the involvement of Maryland physicians in World War II.

▼ ***Report of the Maryland Medical Political Action Committee (MMPAC)***

Hilary T. O'Herlihy, M.D., chairperson, reported:

- MMPAC had moved from sixth place to first place in membership in the country.
- Had increased corporate members within the American Medical Political Action Committee (AMPAC).
- Would work closely with AMPAC to enhance the membership and response to the medical community issues.
- Urged Med Chi members to get involved with PACs and to work with legislators.

▼ ***New business***

Dr. Farah noted that everyone should read the Medicaid 1115 Waiver document that was coming up for discussion on October 20 and be sure that all important issues have been included.

▼ ***Reminders***

The speaker reminded House members to visit the exhibitors and attend the Reference Committee on Saturday.

▼ ***Next meeting***

The next meeting of the House of Delegates would be held on Sunday, September 10, 1995, beginning at 9 a.m.

▼ ***Adjournment***

There being no further business, the meeting was adjourned at 4:50 p.m.

PAUL A. STAGG, M.D.
Secretary ■

Minutes of the Meeting of the House of Delegates
Sunday, September 10, 1995

▼ ***Delegates/guests present***

A list of the delegates and guests present is on file in the executive office of Med Chi.

▼ ***Call to order***

The meeting was called to order at 9:20 a.m. by Allan D. Jensen, M.D., speaker of the House of Delegates, in the Palmetto Conference Rooms of the Princess Royale Hotel and Conference Center, Ocean City, Maryland.

▼ ***Credentials report***

James Chesley, M.D., chairperson of the Credentials Committee, reported that a quorum was present.

▼ ***Report of Reference Committee A***

Catherine Smoot-Haselnus, M.D., chairperson of Reference Committee A, presented the committee's report. Other committee members were George Bone, M.D., Herman Brecher, M.D., Francis Mayle, M.D., Melvin Rapelyea, M.D., and Russell Schub, D.O.

- **Resolution 31-95—Patient access information**

  The House of Delegates approved the resolution as amended by the reference committee and the House of Delegates as follows:

  RESOLVED, That the Public Relations Committee of Med Chi initiate a campaign keeping within the budget

of the Public Relations Committee to educate the citizens of Maryland currently enrolled in managed care plans of the passage of the Patient Access Act and its provisions; and that this information be made available to physicians for patients regarding patients' rights and responsibilities; and be it further

RESOLVED, That the attorney general's office be contacted to ensure that the patient access bill is being enforced by employers and insurance companies.

- **Resolution 32-95—Medicare**
  The House of Delegates' final action on this resolution was to adopt the reference committee's recommendation *not to adopt this resolution.*

- **Resolution 33-95—Managed care secondary payers**
  The House of Delegates adopted the reference committee's recommendation to adopt the resolution with deletion and insertion as follows:

  RESOLVED, That the Medical and Chirurgical Faculty of Maryland's Council on Legislation investigate the policy of third party payers and/or managed care companies regarding nonpayment of deductibles or coinsurance and report to the Board of Trustees; and be it further

  RESOLVED, That the Council on Legislation identify the appropriate entity which would be responsible to require these third party payers and/or managed care companies to fulfill their obligations as secondary insurers to Medicare to pay coinsurance and deductibles as set by Medicare and work legislatively or otherwise to achieve implementation of these objectives; and be it further

  RESOLVED, That the AMA Delegation prepare a resolution to be presented at the 1996 annual meeting of the AMA House of Delegates requesting HCFA's immediate correction and abolishment of this practice.

- **Resolution 34-95—Community health networks**
  The House of Delegates did not accept the reference committee's recommendations to change the resolution and adopted the resolution as it was originally written as follows:

  RESOLVED, That the Medical and Chirurgical Faculty of Maryland is opposed to barriers that prevent physician-owned organizations from competing for full risk contracts;

  RESOLVED, That the Medical and Chirurgical Faculty of Maryland is also opposed to the exclusion of physician organizations which may wish to enter into risk contracts exclusively with HMOs or indemnity insurers; and be it further

  RESOLVED, That these physician organizations should also be included via regulation within the definition of a Community Health Network.

- **Resolution 35-95—Unassigned capitation funds**
  The House of Delegates' final decision was not to adopt the reference committee's recommendation, but to adopt the resolution as originally submitted with the word "physician" to be substituted for "primary care provider" as follows:

  RESOLVED, That the Medical and Chirurgical Faculty of Maryland work legislatively and otherwise to mandate that insurers be required to see that the insured choose a physician within thirty days of enrollment.

- **Resolution 36-95—A patient's right to free choice among panel providers**
  The House of Delegates approved the reference committee's recommendation and adopted the resolution with deletion and insertion as follows:

  RESOLVED, That the Medical and Chirurgical Faculty of Maryland aggressively pursue adding language to the effect of the following to Maryland law:

  "Enrollees may seek approved or pre-authorized services from the panel provider of their choice"

  and be it further

  RESOLVED, That the Council on Legislation take appropriate action to see that this issue is addressed during the 1996 Maryland legislative session.

- **Resolution 37-95—Managed care clinical protocols and establishment of an independent appeals board for managed care decisions**

The House of Delegates approved the reference committee's recommendation and adopted the resolution with deletion and insertion as follows:

RESOLVED, That the Council on Legislation urgently seek to have established in Maryland, through legislation, an Independent Appeals Panel system whereby a patient may have simple recourse to a lawful community authority for appealing managed care decisions, and with adjudicating panel members who are nonparticipating and financially disinterested from the managed care entity under question.

- **Resolution 38-95**
  Resolution 38-95 was pulled from the original packet that went out with the Call to the House for this meeting by its sponsor, Montgomery County. Montgomery County then prepared another resolution, to introduce as a late resolution. The reference committee heard testimony on this late resolution even though the House of Delegates had not had the opportunity to vote on whether to consider the resolution. The House of Delegates decided not to hear the resolution as a late resolution.

- **Resolution 39-95—Protecting physicians at the peer review process in the current managed care environment.**
  The House of Delegates approved the reference committee's recommendation and adopted this resolution with deletion and insertion as follows:

  RESOLVED, That the American Medical Association work with the Federation of State Medical Boards to adopt a policy to support state legislative efforts and draft model state legislation to protect the integrity and effectiveness of the peer review process by prohibiting managed care companies from automatically terminating providers who have been sanctioned by state medical boards without providing due process to the provider.

▼ ***Report of Reference Committee B***

The chairperson for Reference Committee B, Maurice Furlong, M.D., presented the committee's report. Other members of the committee were George Malouf, Jr., M.D., Ronald Orrell, M.D., Ben Oteyza, M.D., Joanne Waeltermann, M.D., and Karl Weaver, M.D.

PART I. RESOLUTIONS

- **Resolution 40-95—Single unified explanation of benefits form**
  The House of Delegates approved the reference committee's recommendation and adopted the resolution as follows:

  RESOLVED, That the Medical and Chirurgical Faculty of Maryland's Managed Care and Third Party Liaison Committee work with the insurance carriers to develop a single unified explanation of benefits form which the carriers are willing to use; and be it further

  RESOLVED, That the Medical and Chirurgical Faculty of Maryland continue to work for passage of legislation which would require a single unified explanation of benefits form (EOB) which all insurance companies and HMOs would have to use as their notification of explanation of benefits on all insured to the providers of care.

- **Resolution 41-95—Format change in the Medical and Chirurgical Faculty of Maryland annual meeting**
  The reference committee's recommendation for adoption of the resolution with deletion and insertion was approved as follows:

  RESOLVED, That this House consider structuring the annual meeting in a format which would not require physicians to take two days (Thursday and Friday) away from their practices; be it further

  RESOLVED, That a Friday, Saturday, Sunday format or a two-day meeting be considered; and be it further

  RESOLVED, That this issue be referred to the Council on Medical Education for consideration and to report back to the House at the January 1996 meeting.

- **Resolution 42-95—Medical education pool**
  The reference committee's recommendation that this resolution be referred to the Council on Medical Education for study and report back to the House at its January 1996 meeting was approved.

- **Resolution 43-95—Regulator reform**
  The reference committee's recommendation that the resolution be adopted with deletion and insertion and with the addition of "statutory and" before "regulatory" was approved by the House as follows:

RESOLVED, That the Medical and Chirurgical Faculty of Maryland will communicate its opposition to statutory and regulatory changes in the standards or enforcement of laws and regulations which would lead to increased health risks.

- **Resolution 44-95—Elimination of the July House of Delegates meeting**

  The reference committee's recommendation that this resolution not be adopted was approved by the House of Delegates.

PART II. BYLAWS AMENDMENTS

- **6.20 Duties of the officers**

  The reference committee's recommendation that the revision of the bylaws be adopted with deletion and insertion was not adopted, and the bylaws revision was approved as originally submitted by the Bylaws Committee, with "for distribution" inserted as approved by the Board of Trustees, as follows:

  6.20 Duties of the officers

  6.201 Duties of the president. The president shall be the official spokesperson for Med Chi and preside over the meetings of the Board of Trustees. The president shall be responsible for representing Med Chi in all matters concerning the operations of Med Chi and as such will be the officer responsible for the coordination of all Med Chi programs with outside agencies, to include but not be limited to: the Maryland General Assembly, members of the U.S. Congress, all state departments and other officers and agencies dealing with Med Chi. The president may delegate any of these duties to the president-elect, other officers, committee chairpersons, the chief executive officer, or his or her designee, for certain events or periods of time, but remains responsible for the efficient operation of Med Chi.

  6.202 Duties of the President-elect. The president-elect shall assume the duties of the president during absences or periods when the president is unable to perform the duties of the office.

  6.203 Duties of the secretary. The responsibilities of the secretary include the following: Send to the members a notice (call) and agenda for each Board of Trustees and House of Delegates meeting. Review, edit, approve for distribution and maintain custody of the minutes of the proceedings of the Board of Trustees and the House of Delegates. Make the minutes available to members. Sign all certified actions and legal documents. Maintain a file containing current bylaws and rules of Med Chi, with amendments. Receive and maintain a list of the component societies' officers and delegates and alternate delegates to the House of Delegates [Ref: Roberts Rules of Order].

  6.204 Duties of the treasurer. As chairperson of the finance committee, the treasurer shall supervise all of the funds and investments of Med Chi and policies for the internal control of Med Chi receipts and disbursements, and ensure that an audit is performed annually. The treasurer shall have such other duties as are set forth in these bylaws.

- **7.601 Finance Committee**

  The reference committee's recommendation that the bylaw be adopted was approved by the House of Delegates as follows:

  7.601 Finance Committee. The Board shall appoint a committee of its members, and such other active Med Chi members as it deems wise, to serve as a Finance Committee whose duties shall be to advise and counsel the Board regarding Med Chi's financial and investment program and to provide oversight concerning general compensation levels. The chairperson of the committee shall be the Treasurer of Med Chi.

- **8.101 Nominating Committee**

  The reference committee's recommendation that the bylaw be adopted was approved by the House as follows:

  8.101 Nominating Committee. There shall be a Nominating Committee to receive and evaluate nominations. It shall be chaired by the immediate past president of Med Chi, WHO SHALL VOTE ONLY TO BREAK A TIE, and its members shall include one representative APPOINTED BY each of the following:

  a. Baltimore City;
  b. Baltimore County;
  c. Montgomery County;
  d. Prince George's County;
  e. Western County Group (Allegany, Carroll, Frederick, Garrett and Washington Counties);
  f. Eastern County Group (Caroline, Cecil, Dorchester, Harford, Kent, Queen Anne's, Somerset, Talbot, Wicomico and Worcester Counties); and
  g. Southern County Group (Anne Arundel, Calvert, Charles, Howard and St. Mary's Counties).

Submission of these appointments to the Chief Executive Officer shall take place by December 1 of each year and announcement of the members of the Nominating Committee shall be made at the following January meeting.

- **5.501 Delegates**
  The reference committee's recommendation that the bylaws be referred to the Council on Bylaws for reconsideration after a corresponding rule has been adopted to specify the time for submission of the list of delegates and alternates to Med Chi was approved by the House.

- **16.00 Rules of Med Chi**
  The reference committee's recommendation that the bylaws be referred back to the Council on Bylaws to distinguish between the operational rules of the House and Board of Trustees and the "work of Med Chi" which can be interpreted to mean setting the policies of Med Chi was adopted by the House.

- **9.30 Special committees**
  The reference committee's recommendation to adopt the bylaws amendment was approved by the House as follows:

  9.30 Special Committees
  E. Specialist Identification Committee;
  F. Review Committee on Physicians with Bloodborne Pathogens; and
  G. Physician/Patient Relations Committee.

- **5.301 Regular meetings**
  The reference committee's recommendation that a bylaws amendment be adopted to this section was not approved by the House of Delegates. Therefore, this section of the bylaws remains unchanged.

▼ ***Maryland Physicians, Inc. (MPI)***

Lawrence Pinkner, M.D., chairperson, MPI, again addressed the House of Delegates, following the presentation by First Option Health Plan (FOHP) the prior day. Dr. Pinkner stated, "We, the Board of First Option, feel strongly that the First Option Plan offers the most of what we were directed to do: find an avenue for all physicians in Maryland, owned and controlled by physicians, and with benefits to Med Chi Insurance Agency and to help increase the Med Chi membership and influence." He then listed reasons for his belief.

- There were a multitude of advantages to their business plan.
- MPI has explored many options, including managed care companies, and AMA. They all want control.
- The Articles of Incorporation in New Jersey call for the parent company to buy back stock at the then-present value.
- First Option would help select our CEO and president and train them how to continue First Option in Maryland.
- First Option has been cooperative in allowing for changes in the plan; when MPI wanted veto powers, First Option put veto power in the plan.
- There would be something in the plan extra for Med Chi physicians and for the Med Chi Insurance Agency.
- First Option Health Plan has been supported by the four members of the Board of Trustees and eight members of the House of Delegates who are on the MPI Board.
- No deals have been made, no exclusive contracts have been cut, nor do they plan to do so.

Dr. Pinkner concluded his opening remarks by asking the House for a motion to continue to explore the First Option Health Plan.

Catherine Smoot-Haselnus, M.D., Wicomico County, moved *that the House of Delegates give a vote of confidence to MPI to proceed to develop First Option Health Plan of Maryland. The motion was seconded.*

A lengthy discussion ensued regarding MPI and FOHP. Delegates presented many positive and negative comments and questions, including the following abridged remarks.

The MPI board actions have been consistent with the directions we were given. The charge we were given was to start an IPA. I strongly endorse the motion.

In Maryland, $10-12 billion a year is spent on health care. Of that, 40-50% ($4-5 billion) goes to hospitals, and at a 3% profit they gain $120-150 million. About 20% ($2-2.5 billion) goes for providers' fees, and at a 40-50% net, providers gain over $800 million. Insurance companies keep 5-25% of the health care dollar. Other options than FOHP should be explored. Doctors have "deeper pockets" than hospitals. If every Med Chi member put up $5,000, approximately $35 million could be raised as network capital.

After listening through months of deliberations, I have concluded that FOHP are straightforward and represent a reasonable approach.

Can I say to the people I represent that we have a unified organization and move forward, or will we let FOHP come into this state with hospitals in control?

Not speaking for or against FOHP, a decision not to work with FOHP will likely kill the idea of a statewide, physi-

cian-run entity. The window of opportunity will not be open much longer.

Apparently only one or two hospitals in our county would be selected. Will half the county physicians who attend the other hospital be left out? (Dr. Pinkner: In New Jersey, patients could not go to the nonparticipating hospital. The participating hospitals were required to open their staffs to the other physicians.)

There have been problems sustaining our IPA. We need the expertise of successful people and would rather have hospitals on our side than fight against them.

Our physician network was founded in part because of distrust of hospitals. There are sufficient mechanisms in place that as 50-50 partners, physicians will have control.

A physician-run IPA is the ideal. If MPI proceeds with looking at FOHP, it should look at other options as well.

The House of Delegates asked for a physician-run organization. There are several large physician-run networks or IPAs in Maryland today, which have not been contacted. Physicians have great economic strength and we should pursue the original intention.

We are uneasy about the changes in the marketplace and the window of opportunity is small. We should go ahead.

My delegation supports development of First Option of Maryland, and now is the time to act.

We have explored virtually every available option and consultant. FOHP works, and to turn down this opportunity would be a mistake.

My network is up and running, but we need more capital. IPAs do not have regional coverage, and some specialties are carved out. I support this concept.

At this point, George Malouf, Sr., M.D. offered a substitute motion, which he said was agreeable to the maker of the first motion: *that the House of Delegates supports the Board of Trustees' decision to allow MPI to continue dialogue with First Option.* The motion was seconded. Discussion continued.

The issues are that: New Jersey physicians have put together a successful plan, and Maryland physicians have to come up with serious money; and, we need regional sufficiency. We should be buyers of this program as opposed to being sold the program.

Some of us do not have the resources to wait much longer. [FOHP] works in other places. If we put off we will lose. We need to move on now.

I met an excellent salesman and bought something I did not want to buy. We should continue to study all the options.

Any arrangement needs to come back to this House for a final vote. We should continue the dialogue, then present a definitive proposal to the House.

I find in this room an interesting paranoia and fear of the unknown. Let us move ahead, continue discussions, get the facts, and have a special meeting if we need to.

I contributed money to persue this initiative. Important issues have to do with membership benefits, control, and exclusion of hospitals. As discussions continue, we will have a clearer idea of the final product. Everyone agrees there is some urgency.

My delegation supports the substitute motion. The Board of Trustees should continue, and report back to the House in a timely fashion.

We should hire people who know what they are doing. It would be a mistake to do nothing. We should be allowed to continue. (Dr. Pinkner: There is a very definite time constraint.)

We need to put together a program and bring it back to the House of Delegates for approval.

FOHP is regional. We need to be regional.

After a call for the question, the substitute amendment passed, and the substituted motion passed.

A motion was made, seconded, and passed by the House of Delegates to tentatively schedule a meeting on November 18 for an update regarding negotiations with First Option.

▼ *Report 1-95 from the Council on Bylaws*

At the House meeting on September 8, 1995, Report 1-95 from the Council on Bylaws was distributed to the House. The House was then considering whether to adopt the report. Rule 5.4.1, "Procedure for Selection of the List of BPQA Candidates for Submission to the Governor" was extracted. The rest of the report was accepted by the House of Delegates. After discussion, Rule 5.4.1 was also accepted by the House of Delegates.

▼ *Date of next meeting*

A meeting is scheduled tentatively for November 18 to discuss First Option Health Plan. The meeting in January will be held on Saturday, either January 20 or January 27, 1996.

▼ *Adjournment*

There being no further business, the meeting was adjourned at 1:05 p.m.

PAUL A. STAGG, M.D.
Secretary ■

University of Maryland School of Medicine

For each course, additional information may be obtained by contacting the Program of Continuing Education, University of Maryland School of Medicine, Room 14-011, BRB, 655 W. Baltimore St., Baltimore, MD 21201 (410-706-3956) or by calling the phone number listed after a specific program. FAX 410-706-3103.

Surgical dilemmas in glaucoma management, at the Sheraton Inner Harbor Hotel, Baltimore, MD. 7 Cat 1 AMA credits. — **Feb. 23**

Glaucoma diagnosis and management for ophthalmic medical personnel, at the Sheraton Inner Harbor Hotel, Baltimore, MD (Diadactic Session), UMMS Dept. Of Ophthalmology (Workshops). Cat 1 AMA credits available. Fee: $85. Info: Sharon Stenhouse, 410-706-3958, Mary Ann Millar, COMT, 410-328-6533. — **Feb. 23**

Self-Directed CME Activities

Optimal dosing in chemotherapy: adoptive control with carboplatin, video tape, monograph, and test. Expires March 1996. 3 Cat 1 AMA credits. Info: 212-924-3044.

U.S. medical costs and values: primary prevention versus end stage treatment, monograph and test. Expires Aug. 1996. 2 Cat 2 AMA credits. Info: 908-281-3772.

Lipid management for coronary heart disease: a proven hypothesis, audio tape and test. Expires Aug. 1996. 1 Cat 2 AMA credit. Info: 609-497-9743.

Drug-drug interaction: focus on antidepressants, monograph w/response test. Expires Aug. 30, 1996. 2 Cat 1 AMA credits. Info: 203-629-2555.

Continuously throughout the year

Academic rounds and conference, each academic department within the school of medicine has a series of lectures and/or seminars available to physicians. Cat 1 AMA credits available. Info: 410-706-3956.

Miscellaneous meetings

Williamsburg conference on heart disease, sponsored by the American College of Cardiology, in Williamsburg, VA. 18.5 Cat 1 AMA credits. Info: 800-257-4739. — **Dec. 3–6**

The third annual Maryland schizophrenia conference, at the Pikesville Hilton Inn, Baltimore, MD. 4 Cat 1 AMA credits. Fee: $35. Info: Lenna Janick, 410-455-7666. — **Dec. 6**

Modern approaches to office emergencies, sponsored by the Maryland Academy of Family Physicians at the Annapolis Waterfront Hotel, Annapolis, MD. 10 Cat 1 AMA/AAFP credits. Fee: $115/members; $150/nonmembers; $65/allied health professionals. No fee for inactive/life members/residents/medical students. Info: Maria E. Delgado, M.D., 410-747-1980. — **Feb. 3–4**

Cardiovascular conference at Snowshoe, sponsored by the American College of Cardiology at Snowshoe, WV. 15.5 Cat 1 AMA credits. Info: 1-800-257-4739. — **Feb. 5–7**

Annual Maryland Thoracic Society research dinner and scientific session, "Obstructive diseases of the lung," at the Belvedere and Stouffer Renaissance Harborplace hotels, Baltimore, MD. Info: Anne Eder, 410-560-2120, ext. 206. — **Mar. 23–24**

Miscellaneous meetings (continued)

Sixth annual current concepts in orthopaedics, sponsored by the Southern Medical Association at the Omni Inner Harbor Hotel, Baltimore, MD. Cat 1 AMA credits available. Fee: $295/SOA members; $359/SMA members; $495/all other physicians; $50/residents/fellows; $100/nonphysicians. Info: Michelle Williamson, 205-945-1840. — May 16–18

48th annual meeting, scientific session & exposition, sponsored by the Maryland Academy of Family Physicians at the Sheraton Fontainebleau Hotel, Ocean City, MD. 26.5 Cat 1 AMA/AAFP credits. Fee: $280/members; $325/nonmembers; $110/allied health professionals. Info: Leonard H. Raucher, M.D., 410-747-1980. — May 16–19

Continuously throughout the year

American College of Cardiology, The Heart House Learning Center, in Bethesda, MD. Info: 1-800-257-4737

Advanced echocardiography: case studies and concepts.	Dec. 11–13
Problem solving in interventional cardiology.	Jan. 8–10
Interventional echocardiography: transesophageal, exercise, pharmacologic, and intravascular—emphasizing case studies.	Jan. 18–20
Congenital heart disease in adolescents and adults.	Jan. 22–24
Advanced echocardiography: illustrative case studies and latest techniques.	Feb. 5–7
Molecular biology for the cardiologist.	Feb. 21–23
Advanced clinical cardiac electrophysiology.	Feb. 26–28
Cardiovascular surgery: challenging management problems in coronary artery diseases, valvular heart disease, and thoracic aortic pathology.	Feb. 26–Mar. 2
Echocardiography for sonographers and cardiology trainees: 2-D/Doppler, color flow imaging, TEE and stress echo— practical review.	Mar. 7–9
Echocardiography in coronary artery disease: live demonstration and interpretations of exercise and pharmacologic stress echo.	April 10–12
Advanced pediatric cardiac ultrasound.	April 15–17
Cardiac pacing—1996: new indications for pacing, rate adaptive pacing updates, update on cardioversion–defibrillation.	April 18–20
Transesophageal echocardiography: live demonstration of technique, image orientation, interpretations, and current and evolving applications of biplane and multiplane TEE.	April 24–26
Echocardiography as we approach the year 2000—teleconference.	April 27
Aggressive management of cardiovascular emergencies featuring the role of urgent echocardiography.	May 1–3
Nuclear cardiology for the technologist.	May 6–8
Recent advances in clinical nuclear cardiology featuring case review with the experts.	May 9–11
Pediatric cardiac catheterization update—1996.	May 13–15
Echocardiography: a clinical review—emphasis on TEE, stress echo and Doppler hemodynamics.	May 23–25

Miscellaneous meetings (continued)

Fluorescein angiography conference, sponsored by the Retina Center of Maryland, Baltimore, MD. First and third Mondays of each month; 8:00–9:00 am. Fee: none. Info: C. Love, 410-337-4500.

Sinai Hospital of Baltimore medical grand rounds, in the Zamoiski Auditorium on Thursdays, 9:00 - 10:00 a.m. Info: 410-578-5528.

The renin-angiotensin system	**Dec. 7**
Community-acquired pneumonias	**Dec. 14**
Medical interviewing and the doctor-patient relationship in the managed care era	**Dec. 21**

St. Joseph Medical Center's Minimally Invasive Training Institute. Surgical training seminars in Towson, MD. Seminar fees: $750/spine; $600/others. Course fees: $2,250/spine; $600/others. Info: Colleen Galloway, 410-337-4843.

Orthopedic surgery

Laparoscopic or thoracoscopic spinal seminar. 7 Cat 1 AMA credits.	**Dec. 4**

The Johns Hopkins Medical Institutions

All courses at the Thomas B. Turner Building unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Medical Education, 720 Rutland Ave., Baltimore, MD 21205 (410-955-2959).

Eighth annual Wilmer Institute current concepts in ophthalmology. 20 Cat 1 AMA credits.	**Dec. 7–9**
11th Annual frontiers in research and clinical management of asthma and allergy, at the Asthma & Allergy Center, Johns Hopkins Bayview Campus, Baltimore, MD. 15 Cat 1 AMA credits.	**Jan. 19–21**
23rd Annual geriatrics symposium: a board review, at the Stouffer Renaissance Harborplace Hotel, Baltimore, MD. 27 Cat 1 AMA/AAFP credits. Fee: $595/physicians.	**Jan. 24–27**
Basic endoscopic sinus surgery, Cat 1 AMA credits pending. Fee: $895/labs and lectures; $350/lectures only.	**Jan. 25**
Advanced endoscopic sinus surgery. Cat 1 AMA credits pending. Fee: $1495/labs and lectures; $550/lectures only.	**Jan. 26–27**
13th Annual Houston Everett memorial course in urogynecology, 17 Cat 1 AMA credits.	**Feb. 23–24**
37th Annual postgraduate institute for pathologists in clinical cytopathology, 95.5 Cat 1 AMA credits plus up to 22 hrs. of video instruction. **Registration must be received by Mar. 26, 1996.**	
Course A (home study)	**Feb.–April**
Course B (Johns Hopkins Medical Institutions, Baltimore, MD)	**April 15–26**
Hemodynamic monitoring (hands on). 14 Cat 1 AMA credits.	**Mar. 1–2**
Perioperative management: a course designed for practitioners to limit patient risk by proper pre- and postoperative evaluation and care. 20 Cat 1 AMA credits. Fee: $495/physicians; $450/residents, fellows, CRNAs.	**Mar. 3–6**
Spectrum of developmental disabilities XVIII. 20 Cat 1 AMA credits.	**Mar. 18–20**

The Johns Hopkins Medical Institutions (continued)

15th Mid-Atlantic regional meeting of the Society of General Internal Medicine. Cat 1 AMA credits available. Fee: $100; $30/residents and fellows.	**Mar. 22**
Nuclear oncology. 19 Cat 1 AMA credits.	**Mar. 25–27**
Diagnosis and treatment of neoplastic disorders. 14 Cat 1 AMA credits. Fee: $300/postmarked by Feb. 1, 1996, $325/physicians; $150/residents, fellows, allied health professionals.	**Mar. 28–29**
Biological response to orthopaedic implants, at the Stouffer Renaissance Harborplace Hotel, Baltimore, MD. 12 Cat 1 AMA credits.	**April 12–13**
24th Annual pediatric trends. 42 Cat 1 AMA credits. Fee: Postmarked by Feb. 15, $650/ physicians; $450/allied health professionals. Postmarked after Feb. 15, $695/pysicians; $495/ allied health professionals.	**April 15–20**
Tenth annual mood disorders symposium. 5 Cat 1 AMA credits.	**April 23**
Pediatric allergy and immunology for the practitioner. 14.5 Cat 1 AMA credits.	**April 25–26**
The first international conference on the exstrophy-epispadias complex.	**May 1–2**
13th Annual Wilmer nursing conference.	**May 3**
Critical issues in surgical pathology.	**May 3–4**
41st Annual topics in clinical medicine. 40 Cat 1 AMA credits.	**May 13–17**
Basic concepts in dysphagia diagnosis and management, Stouffer Renaissance Harborplace Hotel, Baltimore, MD. 6 Cat 1 AMA credits.	**May 29**

PHYSICIAN'S RECOGNITION AWARD

During September 1995, the physicians listed below received the American Medical Association (AMA) Physician's Recognition Award. Established in 1968, the award's purpose is to encourage physician participation in continuing medical education and to recognize those physicians who have voluntarily completed programs of continuing medical education.

Massoud B. Alizadeh
Stewart L. Baker
Robin L. Bissell
Oliver M. Colvin
William R. Coyle
Pedro S. De Borja
Ivan J. Fuss
Todd D. Heller
Walter T. Johnson
Shin E. Kim
Martin L. Lipson
Robert W. Lisle
Edward L. Morris
Charles R. Staubs
William C. Wessells
Chas A. Winternitz

The Johns Hopkins Medical Institutions (continued)

Sixth multidisciplinary symposium on dysphagia, at the Stouffer Renaissance Harborplace Hotel, Baltimore, MD. 14 Cat 1 AMA credits. **May 30–31**

Clinical trials. 15 Cat 1 AMA credits. **June 4–5**

Interface of biomechanics and cell biology in orthopedics. **June 6–8**

Advanced pediatric life support. 20 Cat 1 AMA credits. **June 10–12**

Age-related macular degeneration: update 1996. **June 14–15**

Continuously throughout the year

Visiting preceptorship in pediatric critical care medicine. Ongoing five-day preceptorship by appointment. 40 Cat 1 AMA/PRA credits. $600.

The department of radiology and radiological sciences offers several courses in abdominal and obstetrical ultrasound. Info: P. Williams, 410-955-3169.

Visiting physicians. Offered throughout the year for experience in the lab and participation in read-in sessions; by appointment only. 40 Cat 1 AMA/PRA credits. $500.

Johns Hopkins medical grand rounds. Accredited audiovisual continuing education series of case discussions for clinicians; 30 topics per year in five bimonthly programs. Individual and group subscriptions. 40 Cat 1 AMA/PRA credits. Info: 410-955-3988.

Johns Hopkins sports medicine grand rounds. Accredited continuing education series of case discussions by a different presenter on the first Thursday of each month. Info: Carol Kelly, 410-383-0600.

PHYSICIAN PLACEMENT SERVICE

The Medical and Chirurgical Faculty of Maryland maintains a Placement Service for the convenience of Maryland physicians, hospitals, and communities in search of candidates for positions available in our state. A detailed description of such opportunities should be forwarded to:

Physician Placement Service
1211 Cathedral Street
Baltimore, MD 21201
410-539-0872
1-800-492-1056

Physicians wishing to locate in Maryland are invited to submit a résumé to be kept on file with the Physician Placement Service. Candidates are requested to inform the Faculty when they are no longer available for consideration opportunities in Maryland.

MMJ announcements for physician placements in the classified advertisements are charged at the regular classified advertising rate.

STRAIGHT
Forward

INFORMATION FOR AUTHORS

Straight Forward, a quarterly publication by the Physician Rehabilitation Committee of the Medical and Chirurgical Faculty of Maryland, informs Maryland physicians and other health care providers of developments in the areas of substance abuse, mental health, impairment, and recovery.

To accomplish this goal, the editorial consultants seek original informative or philosophical manuscripts on addiction, recovery, practice/patient management, and mental health. Calls for manuscripts on specific subjects will appear in future *Straight Forward* issues.

REQUIREMENTS FOR ARTICLES

1. Maximum length 2,500 words (about 10 double-spaced typed pages)
2. For references to other works within an article, cite the following information:
   a. author(s),
   b. complete title of work cited,
   c. title of journal, publication, and publisher,
   d. year of publication,
   e. volume number,
   f. first and last page number.
3. Submit two copies of the article, typed, double-spaced, with numbered pages and principal author's name on each page.
4. If possible, accompany the hard copies with an IBM-compatible WordPerfect disk (3 1/2" or 5 1/4").
5. A transmittal letter must accompany each submission and must contain the following elements:
   a. the signature, full name, degree, title, and affiliation of the author(s);
   b. a statement that the author(s) participated in forming the concept and drafting the article and take responsibility for its content and accuracy;
   c. a statement granting *Straight Forward* copyright if the article is accepted for publication.

For a copy of a transmittal letter to which you can add information specific to your article, call 410-962-5580 or 1-800-992-7010.

Send submissions to *Straight Forward*
1204 Maryland Avenue
Baltimore, MD 21201

The managing editor will acknowledge receiving your submission immediately, and will notify you of its status for publication as quickly as possible, generally within a month. Thank you for your interest in *Straight Forward*.

The editorial consultants currently seek articles on the following topics:

- spirituality in recovery;
- addictions in the elderly;
- treating chronic pain in the presence of addiction;
- specialty-specific problems in managing addicted patients.

Parris N. Glendening - Governor of Maryland

Martin P. Wasserman, M.D., J.D., Secretary
Department of Health and Mental Hygiene

J. Mehsen Joseph, Ph.D., Director
Community Health Surveillance & Labs Admin

Ebenezer Israel, M.D., M.P.H., Director
Epidemiology and Disease Control Program

DHMH Maryland Department of Health & Mental Hygiene

EPIDEMIOLOGY AND DISEASE CONTROL PROGRAM

201 West Preston Street, Baltimore, Maryland 21201 (410) 225-6700

December, 1995
Surveillance of Communicable Diseases and Electronic Information Sharing in Maryland

The Epidemiology and Disease Control Program (EDCP) has formulated the following plan to establish a model surveillance program for communicable diseases (excluding AIDS) in the State that should serve Maryland well into the 21st century. The EDCP plan for electronic information sharing with the general public, with health care providers, and with medical laboratories is also discussed along with the roles of local health departments and the EDCP.

This plan assumes that the funding available for its implementation will be from (and limited by) existing and anticipated Federal sources. Methods of surveillance described in this plan may be applicable to other conditions such as chronic diseases, cancer, injury and blood lead elevations; however, surveillance for those conditions is not covered in the following description.

BASIC COMPONENTS OF MARYLAND'S SURVEILLANCE PROGRAM

The basic components of Maryland's surveillance program are as follows:

Passive surveillance: The DHMH currently obtains surveillance data through mandated notifiable disease reporting. Passive surveillance is inexpensive and useful in studying trends. Our studies have shown that the completeness of reporting is anywhere from 10% (Lyme disease) to 90+% (tuberculosis).

Passive reporting mandated by regulations and laws, however, does not allow for dynamic and quick addition or deletion of diseases under surveillance. The most important drawback is the inability of the current system to identify non-reportable illnesses occurring in large numbers in the community (e.g., diarrheal illnesses, coughs and colds due to different upper respiratory viruses, antibiotic-resistance shifts, etc.), rare diseases (e.g., Hantavirus illnesses) or diseases of unknown etiology (e.g., unexplained deaths or pneumonia of unknown etiology).

Until more automation takes place in clinics and sharing of information is standardized, we will continue to rely heavily on passive surveillance.

The following steps are underway to improve our present passive surveillance system:

- Make provider reporting of diseases less cumbersome. Physicians will have the option of reporting by voice mail, fax, and e-mail, with mailed morbidity cards reserved as a last resort. In this day and age, relying on the postal service to deliver surveillance data is not optimal. Once the Health Care Access and Cost Commission data base is operational, physicians will report all their encounter data by ICD-9 codes to billing clearing houses where data can be electronically accessed by the LHDs through our office.

- Have laboratories report findings electronically.

- Improve the accuracy of data input. All the analysis in the world is for naught if the data entry is fraught with many errors. A system of quality control indicators are being phased in to assure accurate data input.

- Increase analysis of the data collected in order to identify clusters and trends.

- Increase feedback to health care providers. Such feedback on the data collected will give providers the sense that the data they reported did not end up in a bureaucratic storage dump.

- Involve the general public more in the surveillance process. Positing reports accessible through Internet and periodic release of summary data and trends to the media will be some of the ways to reach the public. The communicable disease surveillance programs at the state and local levels are the most unappreciated programs; the general public has little awareness of how much we contribute to the general safety and welfare of the citizens of Maryland.

Special studies: Several major studies have been done at the state and local levels literally on a shoestring budget. Students, Preventive Medicine Residents, CDC assignees and others have been pressed into service to study areas of special interest. We have collaborated with the University of Maryland and Johns Hopkins School of Hygiene and Public Health to receive funding to carry out surveillance for Lyme disease and bacterial invasive diseases (*H. influenzae*, *N. meningitidis*, *Listeria*, and group B Strep). Special studies could be expanded with additional funding.

Sentinel populations: For emerging and reemerging pathogens, sentinel populations, such as nursing homes or child care centers, will be utilized to offer a way to detect emerging problems quickly.

Population-based studies: The future of Maryland's surveillance efforts will be heavily centered on population-based studies. The growth of managed care companies offer an easy partnership between the health department and HMOs to develop adequate surveillance for the state. The local health departments currently do not have the resources required to perform the follow-up and verifications necessary to make any population study meaningful.

Use of data collected for other purposes: At the state level, the EDCP is currently spending a significant amount of resources to gain access to many available health care data bases such as Medicaid, hospital discharge data, vital records, and the proposed Health Care Access and Cost Commission.

Effectiveness and Resources:

In summary, can we be assured that our surveillance system will immediately pick up an Ebola case or diphtheria coming into Maryland? The honest answer is "maybe". But the institution of all the pieces described above should enable us to improve the chances of detection and will lead to rapid control.

Resources continue to be a major problem at the state and local levels. We are using part of Immunization Program Federal dollars to supplement the disease prevention efforts at the State and local levels. Increased emphasis by Health Officers on surveillance issues will be key to a successful, state of the art surveillance program in the 21st century.

ELECTRONIC INFORMATION SHARING

The following is the EDCP plan for electronic information sharing with the general public, with health care providers, medical laboratories. Information is also provided on the roles of local health departments and the EDCP.

Health Care Providers:

Health care providers will have access to health department information and health alerts and bulletins primarily through Internet. Electronic mail and voice mail will also be available.

1) **Internet Public Health Library** (Vaccine recommendations, informed consent forms, fact sheets, Q & As, program descriptions, and telephone numbers.

2) **Alerts**:
   a) Bulletins on EDCP Internet www web page, Med-Chi forum and SAILOR.
   b) Fax information to selected personnel at hospitals (Emergency Room, Internal Medicine, Pediatrics, Obstetrics and Gynecology, Infection Control, Infectious Diseases) whose specialties are affected. For example, plague alerts or Ebola virus alerts will go to infectious disease specialists. Guillain-Barre alerts would go only to neurologists.

3) **Voice mail** to receive feedback on our performance from providers without computer access.

4) **Reporting**: Communicable disease reporting can be made by voice mail, fax, and e-mail. On-line reporting may be possible through EasyLink mail boxes (AT&T) or by provider-based software that would dial LHDs or EDCP for reporting via modem.

5) **Accessing Registries**: The immunization registry (Maryland State Immunization Information System) is an example of an interactive registry system whereby providers submit the necessary information that is shared to provide the best care for Maryland children.

6) **Obtaining answers to questions** from LHDs and ID specialists through bulletin boards, e-mail, or chat sessions.

7) **Accessing online conferencing** on public health topics.

8) **Accessing video conferences**.

9) **Accessing Fax-on-demand services** to receive forms/information sheets needed in practice.

Medical Laboratories:

Medical laboratories will report conditions and diseases electronically via dial-up modems to EDCP. Information will then be shared with the jurisdictions instantaneously thus avoiding postal delays and interjurisdictional mail. Another very important advantage of this electronic reporting is the overall improvement in surveillance data by minimizing transcription errors and eliminating omissions of variables.

General Public:

Citizen access (individuals or businesses) to computerized health department information will be primarily through Internet. In most local jurisdictions, Internet connection will be through local libraries (e.g., SAILOR) or commercial carriers (e.g., CompuServe). Health information to be shared will be stored in text format (SAILOR) and graphics (World Wide Web). Voice mail and fax-on-demand technologies will also be utilized to provide access to health information for those without computer access.

The following lists the types of information that will be accessible to citizens:

1) Access to information online, such as:

    a) fact sheets on diseases;
    b) commonly asked questions & answers;
    c) clinic hours--LHD specific;
    d) provider and services information--jurisdiction specific;
    e) summary data on diseases and trends;
    f) laws, regulations, and guidelines; and
    g) international travel information.

2) Answers to questions: In addition to telephone queries, citizens can send questions and receive specific information from LHDs via Internet. The electronic format is particularly useful for teenagers who seek anonymity while receiving information on adolescent health issues. Businesses and industries can also save considerable time and energy by using Internet for their correspondence with the LHDs.

3) Electronic town hall meeting: LHDs can conduct conference (chat) sessions on topics for the purposes of educating citizens and receiving feedback before deciding on a particular project.

Local and State Health Departments:

Local health departments will be the central focus of the surveillance, community education, and control measures to prevent the spread of communicable diseases. The Epidemiology and Disease Control Program will have the following roles and responsibilities:

1) Developing programs with special emphasis on cross-fertilization of ideas from other LHDs and other states.
2) Training on epidemiology-related software and control activities.
3) Developing software and epidemiologic tools for use in LHDs.
4) Consulting on program issues and network issues.
5) Supplementing LHD resources.
6) Providing direction for statewide goals and objectives to best serve the citizens.
7) Being the liaison with CDC and other states on communicable diseases.
8) Monitoring progress on communicable diseases control.
9) Supplementing LHD efforts in outbreak control and surveillance. Coordinating multi-jurisdiction outbreaks.
10) Conducting special studies.

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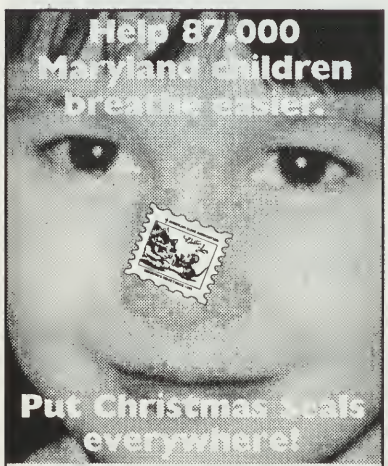
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Since the 1950s, bats increasingly have been implicated as wildlife reservoirs for variants of rabies virus transmitted to humans. In only 6 of the 25 cases of human rabies diagnosed in the United States since 1980, however, has a clear history of animal bite exposure been documented. This finding suggests that even apparently limited contact with bats or other animals infected with a bat variant of rabies virus may be associated with transmission. Data from recent case reports indicate that **in patients who have been in a situation in which a bat was physically present and who cannot exclude the possibility of a bite, postexposure rabies treatment should be considered unless prompt testing of the bat has ruled out rabies infection** (*MMWR Morb Mortal Wkly Rep* 1995;44:625-627).

Caffeine-containing drugs, particularly over-the-counter analgesics, may be a source of sleep problems for older people. Data from the Iowa 65+ Rural Health Study involving 2885 participants indicate that the prevalence of caffeinated medication use was 5.4%. Even after adjusting for other factors that could interfere with sleep (e.g., painful disease, depression, polypharmacy, use of medications known to interfere with sleep, coffee), use of any medication containing caffeine was associated with a 60% greater risk for having trouble falling asleep (*J Am Geriatr Soc* 1995;43:860-864).

After reviewing 10 years worth of data from the San Diego (California) County Trauma Systems (5 adult and 1 pediatric trauma center) Trauma registry, investigators concluded that **high risk behavior is associated with increased injury severity and increased cost.** They also concluded that **public sources fund a disproportionate and increasing share of these costs.** Study data comprised 37 304 consecutive adult trauma admissions. Financial data were analyzed on 28 842 of these. High risk behavior was defined as alcohol intoxication, other drug use, failure to wear protective devices or equipment, and firearm violence injuries. Hospital length of stay, injury severity, and hospital charges were correlated with high risk behavior. The authors argue for legal remedies, more vigorous enforcement of existing laws, and various "user fees" and penalties. The author of an accompanying, invited commentary, however, argues against stringent punitive legislation and in favor of passive preventive strategies such as airbags, guard rails, and firearm locks. He also advocates education and peer pressure to avoid high risk behavior (*Arch Surg* 1995;130:844-851).

In a retrospective review of **193 patients aged 69 and older who were referred for air-flow limitation studies**, investigators studied the effect of age, gender, smoking history, and degree of airflow obstruction on changes in spirometry values and reversibility status after bronchodilator therapy (*Chest* 1995;108:736-740). **The proportion of patients with severe airflow obstruction who had significant reversibility following bronchodilator therapy was greater than the proportion of patients with lesser degrees of obstruction.** Male nonsmokers were more likely to respond than male smokers; female nonsmokers did only as well as male smokers; and female smokers were least likely to respond. Nevertheless, the authors conclude that their findings of response to bronchodilator therapy at all ages and degrees of obstruction have important clinical and therapeutic implications for improving overall functional status in elderly patients.

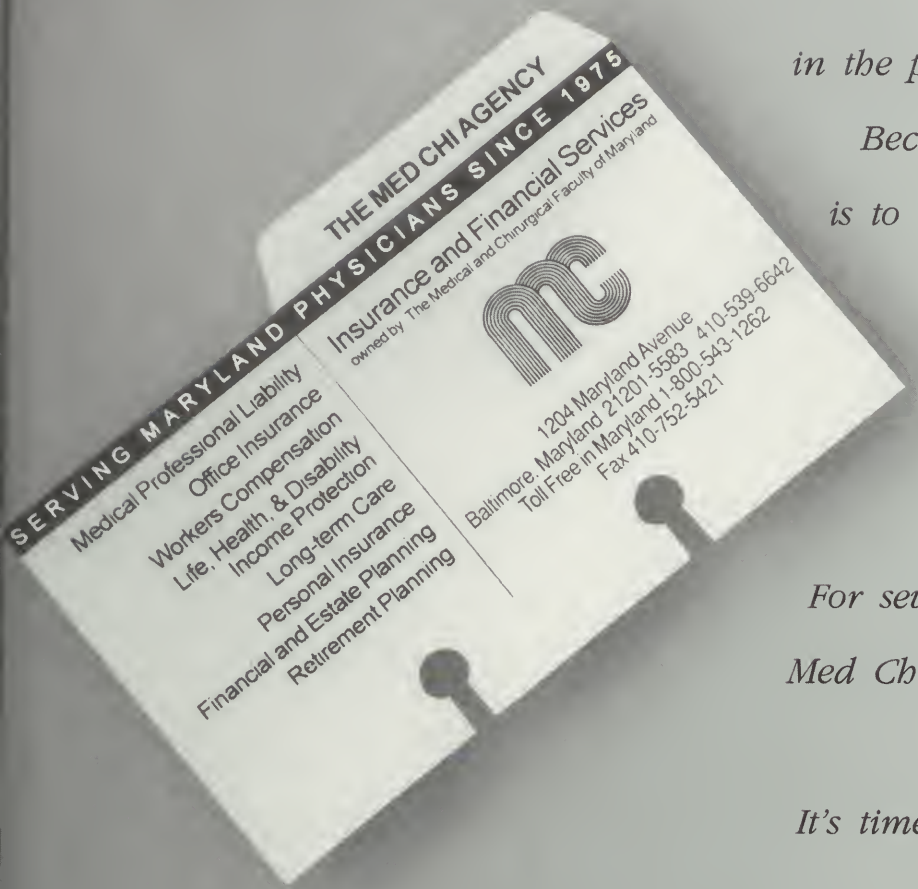
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To assess the cost-effectiveness of *Helicobacter pylori* eradication in the long-term management of confirmed, uncomplicated duodenal ulcer, Canadian investigators used a decision analysis model to estimate the expected costs of three general treatment strategies: immediate *H pylori* eradication; *H pylori* eradication at first ulcer recurrence; and continuous maintenance therapy with ranitidine hydrochloride. The two eradication therapies compared were classic triple therapy and omeprazole plus amoxicillin. Results indicate that **early *H pylori* eradication produces a better outcome and is less costly than intermittent or continuous maintenance ranitidine therapy or treatment to eradicate *H pylori* after ulcer recurrence** (*Arch Intern Med* 1995;155:1958-1964).

When given treatment options, women with urinary incontinence may be more likely to choose behavioral modification or pharmacotherapy over surgery. In a study of 150 consecutive women (48 with stress, 55 with urge, and 47 with mixed urinary incontinence), 61% chose behavioral modification, 25% chose pharmacotherapy, and 14% chose surgery. There appeared to be a significant problem with compliance, however, among those who chose behavioral therapy; 43% failed to return for follow-up visits after receiving full instructions on techniques. Investigators conclude that physicians should ensure that patients are motivated and able to comply with the requirements of a treatment regimen to maximize therapeutic potential (*J Urol* 1995;154:1727-1731).

To evaluate the association between baldness and coronary heart disease (CHD), researchers used data from the Framingham Study on 433 cohort members who were examined for baldness in 1956 and 1962. The subjects were followed prospectively for up to 30 years from the time baldness was first measured, and up to 24 years for progression of baldness. Investigators classified the men into four mutually exclusive groups: no bald areas, 1 bald area, two bald areas, and a degree of baldness in all areas. Pattern of baldness was not recorded. Using a Cox proportional hazards model and adjusting for age and other known cardiovascular disease (CVD) risk factors, they assessed relationships between the extent and progression of baldness and new occurrences of CHD, death due to CHD, CVD, and death due to any cause. Results indicate that extent of baldness was not associated with any of the outcomes, but the amount of progression of baldness was associated with CHD. They conclude that **baldness may be a marker for CHD** (*Am J Epidemiol* 1995;142:828-833).

Although it has been known for some time that there is a high prevalence of chronic respiratory symptoms (chronic cough, chronic phlegm, wheezing, shortness of breath, asthma) among pig farmers in both Europe and the United States, the etiology of those symptoms has remained elusive. **Results of a Dutch cross-sectional study involving 194 pig farmers (94 with and 100 without chronic respiratory symptoms) indicate that use of disinfectants, duration of the disinfection procedure, and pressure used at disinfection are positively related to chronic respiratory symptoms** (*Occup Environ Med* 1995;520654-60). The possibility that disinfectants could be a contributing factor had not previously been considered.



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